Lotus Care 1 Limited

Hurst Nursing Home

Inspection report

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Ratings

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

Overall summary

Hurst Nursing Home provides nursing care and accommodation for up to 22 older people. At the time of this inspection, there were 18 people living at the home, all of whom required nursing care and nine were living with different stages of dementia.

A registered manager was in post when we visited. 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.

All of the people and relatives we spoke with during the inspection said they felt safe in the home. One person told us, "I absolutely feel safe; there is no funny stuff going on in here".

We saw staff deliver care with compassion and understanding. They took time to listen to people to

Summary of findings

ensure they understood them. Staff were seen to be positively and meaningfully interacting with people. There appeared to be a good rapport between staff, people and their relatives.

Staff we spoke with knew how to keep people safe; they were able to identify signs of possible abuse and knew what to do if they witnessed them. However, not all staff had received up to date training in this area.

Staffing levels provided were sufficient to meet the needs of people accommodated.

People and their relatives said that the food at the home was good and choices had been provided. Where necessary, people were given help to eat their meal safely and with dignity.

Care records indicated risk assessments had been carried out, for example with regard to skin integrity, nutrition and hydration. However, records of nursing care and treatment provided were not up to date or complete. This meant that identified risks to people may not be effectively managed to reduce the likelihood of occurrence or recurrence.

Care plans were in place for all but one person who had recently been admitted. However, people, or their relatives, had not been consulted with regard to their needs and wishes to ensure the care provided was person centred. Information had not been kept up to date to ensure it reflected people's current needs. Care plans were not effective in making sure people's needs had been met.

A limited programme of activities had been provided. However, it was not clear how they provided for the needs of people who stayed in their rooms. This meant that they were at risk of isolation and withdrawal.

Not all staff had received supervision and appraisals at regular intervals to ensure they had the necessary skills and knowledge required to carry out their work. Staff training records indicated training had not been kept up to date and some staff had received no training at all in some essential areas, such as understanding dementia and diabetes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS). It is the responsibility of the Commission to monitor how the MCA and DoLS are applied in health and care services it has registered.

Despite having some training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the registered manager and staff demonstrated a limited understanding of their role and responsibilities in this. Where people did not have the capacity to make decisions about their care, the registered manager was unable to demonstrate how this was assessed and how decisions would be made. DoLS applications had been made on behalf of seven people even though there was no evidence to demonstrate they lacked capacity.

People and their relatives had been asked for their views of the quality of the service. However, the registered manager was unable to demonstrate how comments and suggestions received had been considered and, where appropriate, action implemented to improve the service.

A quality assurance system was in place to monitor how the service had been provided and to identify shortfalls. This did not include monitoring complaints, accidents, incidents or safeguarding referrals so that lessons could be learned and action taken to reduce the likelihood of recurrence. There was no evidence to demonstrate, where shortfalls had been identified, action had been taken to make improvements to the service.

We have identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told this provider to take at the back of this report.

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 safe in all areas.

Risks to people had not been managed safely. Records did not demonstrate care plans had been followed for people at risk of pressure sores and dehydration.

People's safety had not been promoted because all staff had not received up to date training in how to identify and report abuse.

Sufficient numbers of suitable staff had been provided to keep people safe and to meet their needs.

Is the service effective?

Requires improvement

The service was not consistently effective.

Not all staff had received appropriate training, which was up to date and ensured they had the necessary knowledge and skills they needed to carry out their duties effectively.

People's care needs were not managed effectively.

People and their relatives had not been consulted about their wishes and preferences to ensure care plans person centred. Care plans had not been updated to reflect changes to care and treatment.

People were supported to have sufficient to eat and drink.

The provider had not always followed the principles of the Mental Capacity Act 2005 in determining people's capacity to make specific decisions and ensuring best interest decisions were made to protect people's rights.

Is the service caring?

Good

The service was caring.

People were supported by kind and friendly staff who responded to their needs quickly.

People's privacy and dignity has been promoted and respected.

Is the service responsive?

Inadequate

The service was not responsive.

There were insufficient activities available for people living with dementia to keep them engaged and avoid isolation.

People and their representatives had opportunities to give their views about the service they received but there was no evidence to demonstrate how the provider had responded to them.

Summary of findings

Records demonstrated people and their relatives had raised concerns and the registered manager had responded appropriately.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Staff were well supported and clear about their roles and responsibilities.

Quality monitoring systems were in place but were not sufficiently robust. Complaints received, accidents, incidents and safeguarding alerts had not been monitored and analysed to determine if patterns could be learned form and used to reduce the likelihood of recurrence. Concerns raised at this inspection had not been identified.

Hurst Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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 22 and 23 October 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor in nursing care

We reviewed this and information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law. We used this information to decide which areas to focus on during our inspection.

Some people who used the service were unable to verbally share their experiences of life at Hurst Nursing Home because of their complex needs. We therefore spent time observing the care and support they received over lunch time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with eight people and to four relatives of people who lived at Hurst Nursing Home. We also spoke with five staff, the registered manager and representative of the provider.

We looked at the care plans, risk assessments and other associated records for people. We reviewed other records, including the provider's internal checks and audits, staff training and induction records, staff rotas, medicine records and accidents, incidents and complaints records. Records for two staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was previously inspected on 17 October 2013 and found to be compliant.

Requires improvement

Is the service safe?

Our findings

Care records indicated risk assessments had been carried out, for example with regard to skin integrity, nutrition and hydration. Where risk assessments identified people were at risk, a care plan, which identified the action to be taken to reduce the risk, had not been routinely drawn up. Where there were care plans for eating and drinking for those at risk they had not been regularly updated, evaluated or reviewed. Fluid charts were present but they had been not filled out or were only partially filled out. The information from these charts had not been used to update, inform or advise care plans. Likewise, turning charts were in place, but on many occasions they were not completed as directed. This meant it was not clear if sufficient action had been taken to reduce to potential risk of pressure sores. Where weights had been taken and, where people had lost weight, there was no care plan which indicated what staff were expected to do to respond to this weight loss and prevent further loss. This meant that identified risks to people had not been effectively managed to reduce the likelihood of occurrence or recurrence. This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they were aware of their responsibilities in relation to keeping people safe. They were able to tell us the different types of abuse that people might be at risk of and the signs that might indicate potential abuse. Staff also explained they were expected to report any concerns to the registered manager or a senior member of staff. This was in line with local safeguarding procedures. Most staff had received appropriate training and guidance in safeguarding policies in procedures although we have found some gaps in staff training that have been addressed in the 'Effective' domain.

All of the people we spoke with during the inspection said they felt safe in the home. When asked one person said, "I absolutely feel safe; there is no funny stuff going on in here". Another person said, "We are well looked after and feel perfectly safe." One relative said their loved one had been in the home for four years and had been very well looked after. They said "I feel (family member) is very safe here and well looked after. We have no concerns and feel confident that (family member) is in good hands."

Nursing staff supported people to take their medicines safely. Staff informed us they were expected to check that the medicines to be administered were in accordance with the prescribing directions recorded on the Medication Administration Records (MAR). They also informed us they would observe that the person had taken their medicine before recording this. If the person did not wish to take their medicine, this would be appropriately recorded in line with the provider's own written procedures. MAR sheets were in the main up to date which evidenced that people received their medicines as prescribed. However, we found gaps during the evening of one day, where the nurse had not signed to confirm the medicine for one person had been administered. Paracetamol had been prescribed for some people. The directions stated that two tablets should be taken four times a day, but no more than eight tablets should be given within 24 hours. However, the time when this medicine had been administered had not been routinely recorded to ensure this guidance was adhered to. This was fed back to the registered manager who agreed to look into it and take action.

Storage arrangements for medicines were secure and were in accordance with appropriate guidelines. People were prescribed when required (PRN) medicines, mainly for pain management. The administration of when required medicines had been recorded. Nursing staff had also routinely recorded information with regard to the reason why medicines had been given and whether they had been effective. This information ensured agreed measures to manage pain were effective and to ensure that PRN medicines had been used appropriately.

The registered manager demonstrated that staffing levels had been determined by using a tool which measured the dependency of people accommodated and how many hours per day they required to meet their needs. The registered manager confirmed that, as a result, staffing levels currently required at Hurst Nursing Home was as follows. Between 8am and 2pm each day staffing levels required were a trained nurse supported by a team of four care assistants. Between 2pm and 8pm required staffing levels were a trained nurse was supported by a team of three care assistants. At night a nurse and a care assistant, who were awake and on duty, were required to provide for people's needs. We looked at staff rotas that were dated from 17 October 2015 to 13 November 2015. They confirmed that staffing levels, identified as being required, had been maintained throughout this period.

Requires improvement

Is the service safe?

Observations on the day indicated that staffing levels provided were in line with that identified by staff rotas. Staff on duty were responsive to people's needs and timely in their interactions with people. We saw no evidence that people had to wait to have their needs met. We found one instance where one person's needs had not been appropriately met. This was due to there not being a care plan in place, that provided staff with guidance with regard to how the individual's needs should be met, and not because staffing levels were insufficient. This has been addressed in the 'Responsive' domain.

Requires improvement

Is the service effective?

Our findings

The registered manager had a limited understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager knew that, if a person was assessed as lacking capacity, decisions about their care and treatment would need to be made on their behalf and in their best interest. The registered manager told us seven people at the home did not have capacity to make certain decisions. However, as they were uncomfortable about carrying out capacity assessments, the registered manager had asked a visiting healthcare professional to do this. The paperwork we looked at identified that assessments carried out were not capacity assessments, as required by the MCA, but were the Abbreviated Mental Test (AMT) to determine if an individual had dementia. The registered manager had also made DoLS applications on behalf of the seven people identified. This meant that the correct process had not been followed to ensure, where there is a question about depriving someone of their liberty, this had been done in consideration of their mental capacity and best interest. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff received an induction when they first started work at the home and participated in training to gain a recognised certificate in care. Most staff received mandatory training, for example in identifying and reporting abuse, infection control, fire safety procedures and safe moving and handling techniques. However, we found instances when training was out of date and when some staff had received no training. For example, training in fire safety was out of date for four of the eighteen care and nursing staff, whilst training in health and safety was out of date for six of the care and nursing staff. Training had also been provided based on the specific needs of people accommodated, for example, understanding and managing diabetes and understanding the needs of people living with dementia. However, one member of staff had no training in understanding diabetes, whilst five members of staff had no training in understanding dementia and it was out of date for a further two staff. Records of safeguarding training indicated that, of the 18 staff employed to provide care, two of them had not received training since April 2014, and one had not received any training.

Regular supervision and appraisals serve to support staff in their roles, to identify training needs and to inform the registered manager of any performance issues which may need to be addressed. Staff supervision was carried out on a regular basis where training needs were identified, but they were not acted upon. Staff we spoke with informed us that, whilst they had discussed their training needs with the registered manager, no action had been taken to address these gaps. The registered manager informed us whilst they and two of the seven trained nurses had been appraised since January 2015, none of the care staff had. This meant the registered manager was unable to demonstrate all nursing and care staff employed had the necessary skills and knowledge to provide the care people required. This is in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food at the home was both nutritious and appetising. People could choose their meals from a daily menu and alternatives were available if they did not like the choices provided. Staff provided support to people at meal times and monitored food and drink intake as required. However, we identified concerns with regard to how the care interventions to people identified as being at risk of weight loss and dehydration had been managed. This has been addressed in the 'Safe' domain.

The registered manager advised us that the nurse on duty would be responsible for calling the GP when required. People would be assisted to attend appointments at the local surgery but most GPs tended to visit Hurst Nursing Home. We were also advised people could see the GP privately if they wished, but the nurse on duty would usually attend to ensure they knew what treatment or medicine had been prescribed. Care records indicated contact had been made with each person's GP and other health care professionals to arrange visits or appointments. There was also evidence of contact with social services where required. This ensured that people were supported to maintain good health by having good links with health and social care professionals.

Good

Is the service caring?

Our findings

People were very complimentary about care staff. One person said, "I'm very well looked after, I have no problems here". Another person said, "The staff are wonderful, they get a bit busy at times but they are as good as gold." This person added, "My son and daughter live abroad now so I can't see them. So Hurst Nursing Home is my family now; I'm very happy." One relative said they were happy with the care and found the communication to be, "Very good." They added, "When (family member) became ill and needed medical help, they kept me up to date with all the developments. I liked that, as I felt 'in the loop' and involved."

The registered manager advised us that all the staff employed at Hurst Nursing Home were expected to communicate with people in a kind, polite manner and make sure there was time to listen to people. We were show a copy of the home's value statement which stated, 'Compassion – we respond with humanity and kindness to each person's pain, distress, anxiety or need.' This was on display in the staff room so that all staff were reminded of the beliefs that underpinned the service provided.

We asked staff on duty about the care needs of identified individuals and how they should be met. They demonstrated they were knowledgeable about the care each person required and appreciated the importance of respecting people's individuality. Staff told us they were expected to attend a hand over meeting at the beginning of each shift where they learnt about the current needs of individuals and how they were expected to meet them. They also said, if they needed to, they would refer to each person's care plan to ensure they had the necessary information to meet people's needs.

We also asked staff how they preserved people's privacy and dignity. They told us that they knocked on doors before entering people's bedrooms and made sure that curtains are drawn when they were providing people with personal care. People told us that staff were polite and respectful. Our observations also confirmed this. For example, we saw a screen was drawn across the lounge when people were transferred from their wheelchair into an armchair. Staff on duty consistently knocked on doors, closed doors when undertaking personal care and referred to people by their preferred names.

We saw staff deliver care with compassion and understanding. They took time to listen to people to ensure they understood them. Staff were seen to be positively and meaningfully interacting with people. There appeared to be a good rapport between staff, people and their relatives.

Although staff respected people's individuality and people felt their preferences were taken into account in their care, people were not aware of their care plans and could not confirm that their views and opinions were taken into account in creating the care plan. We have explored this as a breach of regulation in the 'Responsive' domain.

Inadequate

Is the service responsive?

Our findings

The registered manager informed us that a new document, entitled 'Knowing Me', had been developed. The purpose of this was to provide a 'pen picture' of each person, including their previous life history and their achievements, so that staff would be made aware of their background. The aim was for each person to have personalised and responsive care. We were advised that 'Knowing Me' documents been completed for four people, whilst two people had refused to provide information about their past when they were asked. However, from the records we looked at, they appeared to have been used as a hospital passport to provide information to ward staff about the person when they had been admitted to hospital, rather than as a tool to build a life history to inform staff what interests people had.

People that we spoke with did not know what a care plan was; they could not confirm that their views and opinions of the care they required had been sought when they had been drawn up. There was little in the way of life histories recorded to build a person-centred care approach. People's personal life styles and interests had not been documented when each person's needs had been assessed and, therefore, had not been used to impact on care delivery.

One person had been admitted to the home two days before this inspection. The registered manager stated this was an emergency admission from a hospital that was out of area. As a result the registered manager had not visited the person but had conducted an assessment of the person's needs by telephone with the ward staff. A care plan had not been written but, the registered manager stated, this would be done in the next few days when they had become more familiar with the person's needs.

We observed the person, who was sitting in the lounge, frequently called out for assistance, and asked what they should do as they did not know where they were. This person also stood up unaided and attempted to walk without a walking frame, although this was beside their chair. Staff did go to speak to this person, but they did not appear to know how to answer them. For example, one member of staff said, "Just chill out and relax; watch the television." But clearly the person was not satisfied with the response as they continued to call for help after the member of staff had gone. At one point a member of staff brought in a sensor mat which was put down beside the person. This mat would sound an alarm every time the person walked over it. However, it was not clear why this had been done and we saw no evidence that the person's consent had been sought to do so.

When we spoke with them, they seemed pleased to speak with someone. They told us they were disorientated because the staff seemed to be rushing past to go somewhere and did not understand what was happening around them. The registered manager was unable to demonstrate how this person's admission had been planned and how their needs would be met as they settled into their new surroundings. From our observations the staff were struggling to understand and meet this person's needs in their first few days as a new resident.

With the exception of the newly admitted person, each person had a care plan which had been written, organised and implemented by senior management. There was no evidence that staff were empowered to take the initiative and get involved in care planning or person centred care. There was little evidence that the care plans influenced the delivery of care. Four of the 16 care records indicated care plans had been reviewed in September 2015 and, before that, in July 2015 whilst the remainder had been reviewed each month. There was no evidence that care plans had been changed despite changes in treatment. For example, a new treatment for a pressure sore, prescribed after the GP had visited the person in October 2015, had not been updated in the person's care plan. This meant that staff may not be clear on how to support the person with their changing needs. The registered manager was unable to demonstrate that care and treatment provided was appropriate, met people's needs or reflected their individual needs.

During our inspection we saw no evidence of social activities or entertainment being provided to meet people's needs for social stimulation. There was a notice of some activities displayed on a notice board which included visits by the hair dresser and some music sessions. However, care records we looked at showed little evidence that people had been engaged in meaningful activity or had support to access the community if they wished to. There were no plans in place for activities or stimulation for those people who remained in bed. This placed people at risk of social isolation and withdrawal which could exacerbate or

Inadequate

Is the service responsive?

deteriorate people's dementia needs. People's needs in relation to their social and occupational needs had not been assessed and planned for to meet their individual needs.

We were informed that there was a handover meeting at the beginning of each shift between the staff arriving and leaving. The nurse on duty, who was finishing their shift, was responsible for ensuring appropriate information about the current needs of people was communicated to the staff who were about to start work. Information was provided verbally and within a handover report. The written information consisted of the name of each person and a brief summary of their medical conditions. However, the information was vague and generic with insufficient details recorded about people's current needs and changes. There was no evidence in records of guidance or directions for staff to follow to demonstrate how care was to be delivered in a personalised and responsive manner.

The above demonstrates that the provider had not ensured that people's care and treatment was appropriate, met their needs and reflected their preferences. This is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were informed that meetings with people and their relatives had been arranged every two months. We were shown a copy of the most recent meeting which took place in June 2015. The findings of a recent satisfaction survey were discussed which included concerns about the lack of activities and outings, insufficient staffing levels, and the need for some areas of the premises to be redecorated. The minutes stated that those attending the meeting were assured staffing levels were sufficient to meet people's needs. However, apart from a note in the minutes, the registered manager was unable to demonstrate how this had been achieved. In addition, the attendees were also assured that consideration would be given to making improvements in the other areas discussed. However, apart from the note in the minutes, the registered manager was unable to demonstrate that action had been taken to provide additional activities and outings and to begin redecoration as requested by people and their relatives. Therefore, they could not provide evidence to demonstrate they listened to people's experiences and concerns, and had made improvements to the service where required.

A written complaints procedure was available and any complaints received had been recorded in a complaints log. We were shown the log and reviewed the complaints that had been received since we last visited. The records demonstrated that they had been fully investigated and the outcomes shared and discussed with the complainant. The registered manager confirmed that, on each occasion, the complainant indicated they were satisfied with the outcome. However, they could not provide evidence to confirm they had learned from complaints and concerns they had received and made improvements to the service where necessary.

The above evidence demonstrates that the provider had not sought and acted upon the feedback of people's experiences to improve the quality of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

Feedback about the service from people, staff and visiting professionals had been sought through satisfaction surveys. Documents we reviewed indicated that the last survey took place during a period between June and September 2015. Responses in the selection of surveys we looked at ranged from satisfactory to very good. One person commented, "Everyone is so friendly and helpful, the food is nice and, if I want something different, they will accommodate me where possible." They also indicated they did not know how to complain if they had concerns. Another person indicated that their daily care provision was poor. They were unable to choose when they wanted to get up in the morning and when to go to bed at night. The registered manager was unable to demonstrate that responses received had been analysed and where such comments had been made, which indicated a shortfall in the service provided, action had been taken to address them.

The manager also provided us with documentary evidence that demonstrated how the service had been monitored. This included audits of care records, infection control audits, monthly health and safety checks of the premises and equipment such as slings and air mattresses. Three of the four care record audits examined, completed in August and September 2015, identified that wound assessment records were not complete; one of which had not been updated since 2012. The infection control audit, carried out in September 2015, identified that, to ensure good hand hygiene and cleaning practices are followed, all staff needed 'to be observed regularly'. However, there was no evidence that, where shortfalls had been identified, remedial action had been taken.

We were also given copies of reports made by a representative of the provider when they conducted visits to Hurst Nursing Home to monitor the service provided during July, August and September 2015. They included a section entitled, 'Action required as a result of this visit.' However, this section did not include any required actions with regard to shortfalls identified by the representative when records were examined. For example, reports indicated that care plans were routinely checked. Reports we looked at for each month stated, 'Care Plans checked for a sample of residents. There were still some issues that were still outstanding. I have relayed this information to the Registered Manager who will be making the relevant Named Nurses aware of my findings. I expect this to be complete on my next visit.' However, there was no indication that, given the recurrence of this, what further action had been taken to ensure required improvements had been made. Nor was there evidence that shortfalls identified in care record audits, infection control audits and health and safety audits, conducted by the registered manager and the nursing staff, had been followed up to ensure they had been addressed.

The representative's monthly report of July 2015 confirmed that, 'There were some minor accidents reported. There is a falls plan in place for all residents if they show a repeated pattern. Accident Follow up reporting has been introduced to ensure the Manager audits these accidents effectively and have been used.' Further minor accidents were also reported for August and September 2015. However, the registered manager was unable to demonstrate how incidents and accidents had been monitored in order to identify patterns and learn from them to reduce the risk of further recurrence, where possible.

Each of the above means the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monthly reports included interviews with people, visiting relatives and staff on duty, and reviewing a selection of records and documents. The report indicated that comments made by individuals were positive. For example, when one person was asked about the care they received the representative reported that, 'they could not fault the girls. They come whenever he rings the call bell. He said they are always respectful and knock on the door and tell him about the procedures they are about to carry out. He was extremely happy with the food also and said that their relative was very attentive and would come to see him every day.'

People we spoke with said the home was managed well and they had no concerns. One person said, "We are very well looked after because the home is well run." Another person said, "On the whole it's a well-run establishment." A third person told us, "If something is not right you just need to say and they put it right." Relatives had no complaints about the running of the home. One told us they were happy with how they home was managed and that the level of care was very good. They explained," (family

Requires improvement

Is the service well-led?

member) has been here for three years and appears to be as happy as can be. I feel confident that mum is in good hands. The care staff are very good with her; they are a good crowd."

The staff on duty all indicated that they were happy to be at work, they felt listened to and that management was supportive. They also explained that there was a healthy working relationship amongst staff and they enjoyed looking after the people accommodated.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered manager was unable to demonstrate that the care and treatment to service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Where service users were unable to give consent to care and treatment, the registered person had not acted in accordance with the provisions of the Mental Capacity Act 2005. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person had not ensured that care and treatment was provided in a safe way. This was because risks to the health and safety of service users had not always been appropriately assessed or mitigated. Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	How the regulation was not being met: The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. Regulation 17(2)(b). An accurate, complete and contemporaneous record had not been maintained securely in respect of each service user which included a record of the care and treatment provided to the service user. Regulation 17(2)(c). The registered person had not acted on feedback from relevant persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. Regulation 17(2)(e).
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Persons employed by the service provider had not received appropriate training and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a).