Robert Stephen

Purbeck House Care Home

Inspection report

135 London Road
Waterlooville
Hampshire
PO7 7SH

Tel: 02392261307

Date of inspection visit:
01 February 2018

Date of publication:
30 April 2018

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

Summary of findings

Overall summary

We inspected Purbeck House on the 1st February 2018 and the inspection was unannounced.

Purbeck House is registered to provide accommodation for 15 older people requiring personal care who may have a learning disability or associated mental health conditions and or be living with dementia. This service does not provide nursing care at the time of the inspection there were 14 people living at the home.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were not assured effective infection control measures were in place. Areas of the home did not appear clean and were in need of deep cleaning. Equipment such as commodes, toilet frames and seats; had not always been maintained to an appropriate standard to ensure peoples safety.

The home had not taken appropriate steps to ensure that effective processes to access, monitor, and mitigate risk relating to health, safety and welfare of service users. Care plans lacked clear information for staff on how to mitigate the risks associated with people's behaviours.

The service had not notified the care quality commission (CQC) in relation to one safeguarding event which the home had reported to the local authority safeguarding team which meant they had not fulfilled their legal obligation in relation to this matter.

People received their medicines in a safe and effective way from staff that had been trained to administer these. However, there was a lack of guidance where people had been prescribed medicines to be given "when required" (PRN).

There were sufficient numbers of staff on duty to meet people's needs. Staff worked closely with health and social care professionals to ensure people received effective care in line with their needs.

People's mental capacity had been assessed where this was appropriate. Staff had training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's privacy and confidentiality was mostly respected. Staff knew all people well; they were friendly and helpful. Staff involved people and their families in their care planning as much as possible.

Complaints were managed in line with the provider's policy. The homes complaints policy was displayed.

We found one breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the home were not safe.

The home was not following best practise guidance for cleanliness.

Most risks associated with people's care needs were not always clearly documented.

There was a lack of guidance where people had been prescribed medicines to be given "when required" (PRN).

The home had recruitment procedures in place. We found this process was not always followed.

There were sufficient numbers of staff on duty to meet people's needs..

Is the service effective?

Good

The home remained effective

Is the service caring?

Good

The home remained caring.

Is the service responsive?

Requires Improvement

Some aspects of the home were not responsive.

Care plans did not always include guidance for staff around how care was to be delivered.

There was a lack of information around the home to ensure information was available for people in a format they could read and understand.

There were not always a choice of activities for people to be involved in.

Complaints were managed in line with the provider's policy. The homes complaints policy was displayed.

Is the service well-led?

Requires Improvement

Some aspects of the home were not well led.

The home did not have effective systems to assess and monitor the quality of service provided.

Quality assurance was not always being used as an opportunity to make improvements.

Care plans did not always identify risks associated with behaviours and did not include guidance for staff on how to mitigate the risks.

The provider had not fulfilled their legal obligation in sending notifications to the Care Quality Commission (CQC).

Staff felt supported by the homes management who were approachable and had a clear understanding of their roles in the home.

Purbeck House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced comprehensive inspection which took place on the 1st February 2018. Two inspectors and an expert-by-experience undertook this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had expertise in dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we had about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager. A notification is information about important events which the service is required to send to us by law.

We spoke with ten people who lived at Purbeck House to gain their views of the home. Many people who lived at the home were not able to talk with us about the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to understand the experience of people who could not talk with us. We observed care and support being delivered by staff and their interactions with people in communal areas of the home. We spoke with the registered manager, the deputy manager, a member of care staff and the cook/ maintenance person.

We looked at records including six care records, daily records, five staff files, 12 medication administration records (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us, "Yes, I do. There's always people around. It's not lonely." Another person said, "Very, of course. The staff are very friendly. If I have any trouble, I can go to any of them." Staff we spoke with also felt people were safe. One staff member told us, "Yes people are safe here; we know them well and how to care for them." Another staff member agreed saying, "I think they are very safe." However during our inspection we found some aspects of people's care needed further review to ensure the safety and welfare of people.

Areas of the home were in need of deep cleaning. Across the home we identified 22 different infection control issues in people's bedrooms, communal bathrooms, the hallway, communal lounges, laundry room and staff toilet. These included soiled commodes, damaged and soiled bath seats, dirty and damaged toilet frames (equipment), a soiled privacy curtain, dirty windowsills and door frames, a damaged mattress and armchairs. The home was not following best practise guidance for cleanliness. The registered manager told us they would address this immediately and provided evidence post the inspection that new equipment had been purchased.

Only one type of disposable cloth and mop was used for all areas of home including toilets, bathrooms and people's rooms except the kitchen. The home was also not following the national colour coding scheme for cleaning materials and equipment in care home. All cleaning items, for example, cloths (re-usable and disposable), mops, buckets, aprons and gloves, should be colour coded using for example red in bathrooms and toilets, blue in lounges, offices and bedrooms, and green in kitchens. The registered manager told us they would address this immediately and provided evidence post the inspection that new equipment had been purchased.

The provider's failure to ensure that people were receiving safe care and treatment was a beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not taken appropriate steps to ensure that effective infection and control measures were in place.
We saw weekly cleaning schedules for the home were complete. COSHH cleaning equipment and documentation was in place and stored appropriately. Control of Substances Hazardous to Health Regulations (COSHH require employers to control exposure to hazardous substances to prevent ill health.

Staff received infection control and food hygiene training. Staff had access to personal protective equipment (PPE) such as hand towels, pump soap. The home undertook monthly infection control audits which monitored the any outbreak of infection. Audits provided for the three month period October to December 2017 recorded there had been no outbreak of infection in the home.

The kitchen was a clean and well managed area of the home with foods labelled and dated clearly. The home had received a five star food hygiene rating from the Food Standards Agency in May 2017.

The home had recruitment procedures in place. We reviewed five staff recruitment records all the relevant checks had been mostly been completed. In one record we saw a newly appointed member of staff had

commenced working however we found only one reference was on file. The home's selection and recruitment of staff policy stated a minimum of two referees would be contacted. We spoke with the registered manager who told us this would be addressed.

Staff had a received training in safeguarding people and had a good understanding of safeguarding policies and procedures were confident to report any concerns they had to the registered manager or report to CQC if they had any concerns they could not discuss in the home. Staff told us they were confident the registered manager would respond promptly and effectively to any concerns they may have. One gave an example of when they had reported a concern which had been dealt with very promptly. Another said, "Abuse is neglect; if something feels uncomfortable, things like bruises, marks unusual behaviours we have to report it all."

Staff had access the homes policies and procedures what were held in a file and were easily assessable. The registered manager was in the process of reviewing them to ensure they reflected best practice and current legislation.

People had care plan in place with accompanying health and risk assessments completed. Most risks associated with people's care needs had been identified. Whilst staff had a good understanding of these risks and how to manage them, these were not always clearly documented. Risks associated with mobility, moving and handling, falls, health conditions such as diabetes and Parkinson's disease and the use of call bells had been assessed. For example, actions taken to reduce risks included; Pressure mats were used in home to alert staff if people left their bed or room at night, pressure mattresses were used to maintain skin integrity, stair gate in place to prevent people going up to third floor.

In another record we saw that risks associated with one medicine had not been identified. For one person who received a medicine to thin their blood which could reduce their ability to clot if they injured themselves, this risk had not been identified and staff had not noted any actions they may need to take in the event this person injured themselves. The deputy manager told us they would address this immediately.

Personal Emergency Evacuation Plans (PEEP) were in place to provide information on how people would need to be supported in the event of an emergency in the home. These were held in people's care records. Accident and Emergency plans were also in place for each person to help in the event of sudden admission to hospital.

Care plans and peoples day to day records were stored securely in the staff office which was locked when unattended. The senior staff member would hold the key when the office was unattended.

The home recorded accidents and incidents as part of the on going monitoring process. All falls and action taken were recorded. Some areas of the home required review to reduce risks of trips and falls.

Electrical, gas, and water checks were completed routinely in the home to ensure this equipment was safe to use. Fire safety assessments and routine checks were completed and staff received training on the safe evacuation of people form the home in the event of an emergency.

A business continuity plan and home emergency evacuation plan were in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

Accidents and incidents were recorded with actions taken. The home's monthly report monitored the number of incidents and accidents each month.

There were sufficient numbers of staff on duty to meet people's needs. The staff rota confirmed that during the day there were two staff on duty plus the registered manager during the week. In addition there was a cook/ maintenance man and housekeeper. At night there were two night waking staff on duty. Staff we spoke with told us "There are enough [staff working].We all work really well together and if anyone is off we all cover. We don't use agency." Another staff member told "Yes [there are enough staff.] We have just taken on another cook to do weekends."

People received their medicines in a safe and effective way from staff who had been trained to administer these. There was a system of audit and review in place for the safe storage, ordering and administration of medicines. However, where people had been prescribed medicines to be given "when required" (PRN) some care records did not give clear information on when these should be given and staff did not always monitor the effectiveness of these medicines. We spoke with the deputy manager who told us this would be addressed.

The home was holding medicines that required stricter controls called controlled drugs. A spot check of these drugs showed the medicines corresponded with the controlled drugs register which two staff had signed when medicines had been given in line with current legislation.

Homely remedies were available for people if these were required. These are medicines which can be bought over the counter at pharmacies and include medicines for pain relief, constipation and indigestion. We saw evidence of review by GP of people medicines to improve their wellbeing.

Good

Is the service effective?

Our findings

People told us the meals were "very good really. They taste nice", "They are always very nice", "They're very good. They suit me down to the ground," and "They have been nicer recently, I don't know why. There's always a good variety."

The provider's mandatory training matrix showed that staff had completed training in fire safety, food hygiene, moving and handling, safeguarding adults, infection control, health and safety, first aid and basic emergency aid, and medication. Some staff had also completed additional training in person centred care and dementia awareness. We noted that not all the training was up to date with some training having recently expired. The registered manager told us they would address this immediately.

Some staff had qualifications National Vocational Qualifications in health and social care and had completed the Care Certificate, a universally recognised vocational, work assessed qualification. Staff felt supported to receive training which allowed them to meet the needs of people. They told us "I have done NVQ 2 and 3 and learned quite a bit about dementia" and "We have training we have to keep up to date like fire and moving and handling, but we do other things too."

Staff received regular supervision and an annual appraisal with their registered manager records seen confirmed this. Staff told us they could raise any issues in supervision and at any time with the registered manager and deputy manager at any time. Separate staff meeting were organised for day and night staff. Staff meetings had taken place in June and December 2017.

A pre admission assessment had been completed for each person and contained detailed information on people's likes, dislikes and preferences. Clear family history details were available and records identified those who were important to the person as well as legal representatives such as lasting power of attorney (LPOA). People's physical, mental health and social needs had been holistically assessed to ensure the care they received was in line with their individual needs.

Minimal technology was used in the home to effectively support the safety and welfare of people. Pressure mats and a pressure relieving mattress were seen to be in use.

Care plans identified specific dietary needs, likes and preferences for people and the cook was aware of these. Staff were aware of the importance of good nutrition and if they became concerned that a person had lost their appetite, was losing weight they told us they would ensure for example, that people were offered snacks and drinks during the day.

The staff weighed people monthly and identified people who were at risk of malnutrition. The registered manager reviewed people's weight to identify people who had lost or gained weight. We saw action plans were in place for people were there were concerns. The information was shared with the cook who signed to confirm they were aware of any changes to people diets.

We observed lunch in dining area and in the living room. In the dining room six people were supported with lunch and in the living room people ate independently. Music was playing in background and the meal was calm with some interaction between people and with staff. Some people chose to eat quietly and leave the dining area when chose to. Two people chose to eat in their room. One ate independently when staff brought her meal. The other required support from staff with pureed meal.

One person was having some difficulty using their cutlery. A staff member spotted this immediately and came over to assist. They asked quietly before intervening, and then left the moment the person could manage on their own again.

People enjoyed a variety of meals in line with their likes, dislikes and preferences. One person told us "You don't really choose. They seem to have things on certain days. On Friday it's fish and chips, on Sunday a roast and a roast on Wednesdays. They perhaps have sausages on Monday, something like that." Other people said "They don't tell us what it is.", "In some places, like hospitals, they come round with a list, but here the meals just come. It's called and we sit down."

A four week rolling menu of meals was provided and the cook was able to prepare other options for people if they did not want the daily selections. All food was freshly prepared, and staff had a good understanding of people's preferences and specific dietary needs. For example one person had peas rather than baked beans. People told us the meals were "very good really. They taste nice", "They are always very nice", "They're very good. They suit me down to the ground," and "They have been nicer recently, I don't know why. There's always a good variety."

People were provided with hot and cold drinks throughout the day. Staff provided additional drinks to those who requested one. There was a cold water dispenser that was used to fill people's glasses by staff and one person made use of it. Biscuits were provided with drinks.

Staff worked closely with health and social care professionals to ensure people received effective care in line with their needs. Care records showed people had access to a support form GP, community nurses, dentists, chiropody and optician when this was required. Clear records of all communications with health and social care professionals were kept. People told us they saw their GP. One person told us "'I saw a lady doctor last week" and another person said "I have seen the doctor a lot. The nurse came yesterday for an injection."

Staff had training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about care and treatment. We saw staff sought the consent of people before they provided support or care for them. We looked at care plans in the light of issues of consent and capacity.

People's mental capacity had been assessed where this was appropriate. For two people who had recently been admitted to the home best interests decisions had been made for them to live at the home. Their relative who had lasting power of attorney and health care professionals had been involved in this process before the people came to live in the home. For another person who had deprivation of liberty safeguards (DoLS) in place an application had been made to the local authority to grant further authorisation. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legal authorised under the MCA. The application for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Purbeck house had been adapted to suit the needs of the people living there. The home had a stair lift, hand rails and there was some signage on bathroom doors. However the environment was not dementia friendly,

the ground floor was on different levels and there were steps upstairs taking people to different levels. Changes in floor surfaces can cause some confusion due to perceptual problems which could become a risk if people's condition changed over time.

Good

Is the service caring?

Our findings

People told us that staff treated them with dignity and respect and were kind. They told us the staff were "Very good"; "They do their work well. They're very nice people". One person told us "Most of them are very kind." Another person said 'It's a very good home and everyone is good here.'

People told us they were supported to be independent, staff went out with one person regularly and a support worker went out with another person twice a week. One person went out on their own had regularly and took part in a range of social activities. People told us "I always try to do things for myself especially at night", and 'I always like to be independent. I've always been independent. I go out with my friends.'

People's privacy and confidentiality was respected. We observed that staff knocked people's doors before entering people bedrooms. People told us "'They knock the door". However one person told us "It's not always private. They don't knock the toilet door." We saw in a shared room the privacy curtains had been drawn when staff provided personal care to one person.
We observed kind and effective interactions between people and staff. Staff spent time sitting with people encouraging them to participate in activities. For example, one person became unsettled at the presence of the inspection team in the home and we saw the provider sat with them to do a puzzle and allow them to calm. However, two people sitting in another living/dining room expressed the opinion staff seemed not to have time for them. We observed staff spend little time in the other living room.

It was evident all staff knew all people well; they were friendly and helpful. Staff addressed people by their preferred names and there was a gentle banter with people about things they had done in their lives and what they liked to do. Requests for support were responded to quickly. This was always quickly attended to with good humour and was understood as they needed reassurance.

Staff involved people and their families in their care planning as much as possible. Care plans and risk assessments were reviewed monthly and staff tried to discuss and agree them with people or their representatives as able. We saw people and family members had sometimes signed care plans to show they had been involved in the discussion of these. Records of contact with family members were kept.

Requires Improvement

Is the service responsive?

Our findings

People told us "Sometimes there's jigsaws puzzles or knitting. They do my nails. They had a band and you could sing if you liked at Christmas time and dancing. I like dancing. I go to Age Concern to the lunch club and to the church on a Wednesday. I like being out.", "The day goes quickly. We do different things." However two people commented about the lack of choice in activities. One person told us "At the other home people came in with all sorts of games and everyone got involved. There was a music man who used to play tunes and we used to play a game."

Care plans in place were legible and securely stored. They held clear information on people's personal history, preferences, likes and dislikes and staff had a very good understanding of these. However, whilst care plans were individualised and person centred, they did not always clearly identify the actions required of staff to meet people's needs. Care records held a summary of people's needs and the aims for staff but gave no clear instruction of how to achieve these aims.

For example, one person could become confused at times which made them restless and resulted in them wandering in the home. Care records gave staff no clear information as to how they should support this person to meet this need. Care records showed this person could become aggressive at night although there was no information for staff on how they should support this person with this need. However talking to staff they were aware how to support the person.

For a second person their care plan identified that it was sometimes difficult to communicate with this person. However there was no information available for staff on how to address this need and support the person to communicate effectively with them. Whilst staff had a very good understanding of how to communicate with this person, care records did not reflect the actions which needed to be completed to support this person.

One person's health had deteriorated and they were receiving all care in their bed. This person was comfortable and spoke quietly with us to tell us they were well cared for. Care records reflected deterioration in their condition and actions being taken to meet their needs although there was no information about what setting the pressure mattress should be set at or details of monitoring to ensure the setting was correct. This meant the person was at risk as staff were unaware how it should be monitored or used to ensure the safety and welfare of the person.

For two people who had recently been admitted to the home we saw their relative, who held lasting power of attorney, had been closely involved in planning the care for their loved ones. Care plans also had details of health professionals involved in their care for example the district nurse, community physiotherapy team, chiropodist and dentist.

There were some examples of easy read documents such as the dental passport, but no other information seen around the home to ensure information was available for people in a format they could read and understand. Pictures and information about staff displayed which helped people understand who staff

were. The registered provider and registered manager were not aware of legislation related to the accessible information standard and told us they would look into this immediately and ensure this was implemented.

Complaints were managed in line with the provider's policy and one formal complaint had been received and resolved during 2017. We saw that the homes complaints policy was displayed in hallway however this was not in an easy read format. We asked people if they had ever made a complaint, people we spoke with told us "No, I don't complain much.", "No, I've never had to. I don't find anything that's wrong, they all do their best to help you." and "I've no complaints at all."

Staff told us they found people preferred one-to-one activities and tended to feel overwhelmed by involvement in group activities and did not engage with these for long. Staff advised that some group activities were still sometimes attempted, for example making Christmas cards, and some people would take part, while others would sit and watch.

Activities organised by staff were individualised, they engaged people and made for a pleasant and lively atmosphere in the main living room, but the needs of people in the smaller living/dining room did not seem to be particularly well catered for. Individuals were supported by staff to complete a crossword, a jigsaw and knitting squares to be made into a blanket for cats. However, two people felt they were not offered a choice of different activities.

Activities were discussed during residents' meetings. Staff were aware of what particular people wished to do on a daily basis. Staff told us there had been recent discussion about arranging trips out as people were mobile and more able to cope with going out. People we spoke with all told us they attended resident meetings.

The home provided care for people at the end of their life although there were no people in the home receiving end of life care at the time of our inspection. Care plans were in place to provide staff with guidance on people's preferences, wishes and specific instructions including religious, cultural and spiritual needs in place in the event they required end of life care. One person had clearly identified the music they wanted to be playing as they moved to the end of their life to comfort them. People's preferences had been discussed with them and their family or representative where appropriate. These gave information on how people wanted to be supported as they moved towards the end of their life. This included information about when people did not want to be admitted to hospital for the treatment of their ill health. Families and representatives could be involved in informing these plans.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with had mixed views about the home, when asked if they were satisfied with the home, people responded saying "Well, if I could go somewhere else, I would. "It seems to be alright. It's quiet." "I can't go anywhere else." However when asked if they would recommend the home three out four people asked said they would.

The provider did not have effective systems to monitor trends from risks and audits that would identify were care plans were incomplete so that appropriate action could be taken. Risks associated with behaviours had not always been identified and lacked clear information for staff about how to mitigate the risks associated with people's behaviour in people's care plans. For example, there was no information to identify how staff should 'redirect' a person who had proven to be more aggressive during the night when they were redirected by staff. Staff told us that the person was much calmer and not as aggressive although this did not reflect the information in their care plans.

In a second care plan record there was no information in care plans for staff to support a person who had excessive behaviours in relation to the management of their continence and use of continence aids. Staff knew how to manage and support the person but it was not recorded.

There were insufficient quality assurances in place to ensure that the best delivery of care. The register manager did not seek regular feedback from relatives, people living at the home to gather views to shape and improve the service. When audits were completed these did not identify the shortfalls we had identified. There were no infection control or environmental audits which meant poor infection control practices by staff were not identified.

The registered manager had undertaken a "walk about" of the home in October 2017 to identify issues, some of which were entered into the maintenance log. The registered manager was unable to tell us if they had been completed. We noted that a new carpet had been identified for a room at the end of October 2017 but had not been replaced.

When we asked people if they felt listen to and involved in the home, people responded saying "I don't think so. There's such a lot going on with other people. The staff are always busy.' 'They listen to anyone to make sure everything is all right.' 'Oh yes, the nurses do.

There were occasions when people were asked for feedback. Three residents meetings were held in 2017. People were asked about drinks, food, their room, hair, washing, music, activities and staff. We saw that the manager reviewed the minutes of the meetings but there was no evidence that issues raised were addressed. When we asked people if they attended resident meeting they told us; "Yes, they had one a little time ago. It was only about if people were satisfied with the food. Nothing was said about entertainment and I didn't think to say. I wasn't sure about what other people wanted to discuss." "We have them here. I can't remember what they talked about". "They have them here. We're always in here and they all come in. They ask if we're happy about the meals and different things. They didn't talk about the activities." "They

have had them. Sometimes I didn't want to stay, sometimes I do. I suppose it's quite good really, about what drinks you like and what food." When we asked people if there had been any changes as a result of their feedback no one answered the question.

Services that provide health and care to people are required to inform the care quality commission (CQC) of important events that happen in the service. The provider had not notified the care quality CQC in relation to one safeguarding event which the home had reported to the local authority safeguarding team which meant they had not fulfilled their legal obligation in relation to this matter.

There was evidence that the provider was working with external health care organisations in relation to the care provision. For example the home had regular contact with GP's, district nurses, and other community care teams.

There was a positive culture in the home. Staff felt supported and had a clear understanding of their roles in the home. Some staff had worked in the home for over 10 years. Staff told us that the registered manager was visible in the home and worked with staff supporting the people. Staff told us that communication was good and that they had daily handovers. The home had a records system and a communications book for all staff which staff read. Staff told us "I am very happy here, I love working here," another said "We are a really good team, we know the people who live here really well."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for services users by assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated