Care Quality Commission

Bupa Care Homes (BNH) Limited

Dene Place Nursing Home

Inspection report

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Date of inspection visit: 24 September 2015
Date of publication: 11/11/2015

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

This inspection was carried out on 24 September 2015. Dene Place provides residential, nursing and respite care for older people who are physically frail. It is registered to accommodate up to 30 people. On the day of our inspection 24 people lived at the service. The accommodation is arranged over two floors.

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

There was not always enough staff deployed around the service to meet people's needs. People were at times left for long periods of time without support from staff. People did not feel that there was always enough staff. One person said that there were usually enough staff but said that on the day of the inspection they seemed short staffed.

Summary of findings

Staff did not always have the knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Safeguarding referrals were not always made to the local authority where necessary. However people did say that they felt safe with staff.

Risks were not always managed appropriately for people around concerns that had been identified. Accidents and incidents were not always recorded to identify any trends or minimise reoccurrences. Other risk assessments for people were detailed and informative and included measures that had been introduced to reduce the risk of harm.

Staff were not always knowledgable about their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes.

Staff were not kept up to date with the required service mandatory training or supervisions and there was a risk that people were not receiving the most appropriate care from skilled staff. However staff told us that they felt supported in their roles.

People's nutritional needs were not always being monitored appropriately in relation to referrals to health care professionals. Other aspects of food and nutrition were good. One person said "The chef is great, they would do anything for me" Nutritional assessments were carried out as part of the initial assessments when people moved into the home.

There were occasions where staff were not as caring as they could be and did not always treat people with dignity. However people and relatives felt that staff were kind and caring. One person said "Staff seem to care about me, they check I have washed and help me with my clothes." We observed some kind and caring interactions with staff and people.

People's records did not always include sufficient information to enable staff to provide appropriate care and support. Whilst we were at the inspection we identified that people had not always had the most appropriate care for their needs. We found that not all of the records at the service were accurate and complete for each person.

There were no effective systems in place to ensure the quality of the service. Audits did not always identify the shortfalls in the service.

People said that they understood what medicines they were receiving. Medicines were stored appropriately and audits of all medicines took place. People received their medicines appropriately.

In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and made them safe.

People were safe because the provider carried out the necessary checks on staff to ensure that only suitably qualified staff were recruited to support the people that lived here.

People had access to other health care professionals in a timely way. For example the GP, opticians, community dentist and physiotherapist visited the service.

People told us that before they moved in the manager undertook a pre-assessment of their needs. One person told us that they were visited at home by the manager (with their family present) to assess their needs.

People and relatives said they felt involved in the planning of their care. One person told us that they were very much involved and they also chose to have their family involved as well. Relatives told us that they felt involved in the planning of care for their family members.

There was a complaints procedure in place for people to access and people knew how to make a complaint. One person said "If I wanted to complain I would tell the care assistant or the manager."

People and relatives were complimentary of the activities that were on offer. One person said "The activities are great." There was a wide range of activities on offer for people which included room visits for people, hand bells, musical workshops, manicures and crosswords However people told us that they would like to go out more on day trips but that this wasn't always possible due to the service not having a vehicle.

People and staff felt supported by the manager. One member of staff said "I find her very approachable, everyone gets on well here."

Summary of findings

The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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

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 always safe.

There were not always enough qualified and skilled staff at the service to meet people's needs.

Staff did not always understood what abuse was or how to report abuse if required.

Risks to people were not always managed appropriately. However staff were aware of the risks to people and how to manage them.

People were receiving all of their medicines as prescribed.

Staff were recruited appropriately.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not always have a good understanding of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff did not always have the most up to date training or supervision of the work that they undertook.

Peoples' weight and nutrition was not always monitored. People had access to other healthcare services to maintain good health.

People were supported to make choices about food and said the food was good.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always treated with kindness and compassion and their dignity was not always respected.

People were able to express their opinions about the service and were involved in the decisions about their care.

People were able to access advocacy services if needed and visitors were always welcome.

Is the service responsive?

Requires improvement

The service was not always responsive.

There was not always the most up to date information about people's care needs.

Summary of findings

There were activities that suited everybody's individual needs.

People knew how to make a complaint and who to complain to.

Is the service well-led?

Requires improvement

The service was not always well-led.

There were not always appropriate systems in place to monitor the safety

and quality of the service.

Where people's views were gained this was not always used to improve the quality of the service.

People and staff thought the manager was supportive and they could go to them with any concerns. The culture of the service was supportive.

Dene Place 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. 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 inspection which took place on 24 September 2015. The inspection team consisted of three inspectors, a nursing specialist and an expert by experience in care for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. After the inspection we spoke with one health and social care professional.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. Before the inspection the provider completed a Provider Information Return (PIR).

the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked through notifications that had been sent to us by the registered manager. A notification is information about important events which the service is required to send us by law

During our inspection we spoke with the registered manager, the regional quality manager, 13 people that used the service, two visitors, 11 members of staff and one volunteer. We looked at eight care plans, four recruitment files for staff, medicine administration records one to one supervision records for staff, and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. We observed some care being provided during the inspection.

The last inspection of this home was on 15 October 2013 we found our standards were being met and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

There were mixed opinions from people around whether there were enough staff to support people. One person said, "The nurses always come quickly if I ring the bell but sometimes they are held up if its busy." Another person said that there were usually enough staff but said that on the day of the inspection they seemed short staffed. Another person told us that they sometimes had to wait a long time before staff were able to assist them with their needs. They said, "They need more staff." One relative said their family member had to wait a long time sometimes for staff but "That is to be expected in a home this size." However people said that they felt safe at the service. One person said "Yes I do feel safe, staff are kind."

There was not always enough staff deployed around the service to meet people's needs. Staff said that they didn't have time to sit down and speak with people. One told us "It would be nice if we could talk to people." They said that when there were five carers on duty instead of six they didn't have enough time to spend any quality time with people. According to the rota there was usually at least five carers on duty. On the day of the inspection there were occasions where people were not being responded to in a timely way. One person was calling out to a member of staff, they had called out from the lounge several times. When we went to the lounge we found one lady (who was at risk of falls) was trying to get out of her chair. It was around 15 minutes before any member of staff came into the lounge to assist this person. We saw that staff didn't have time to interact with people throughout the day. Another person told us that they needed to use the call bell to get staff to support them with one aspect of their non urgent care. They said that they could be waiting some time before a member of staff could assist. The manager told us that a dependency tool had not been used to assess how many staff were needed to assist people.

There were not always sufficient staff deployed around the service to ensure that people's care and treatment needs were being met in a timely way. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have the knowledge of safeguarding adult's procedures and what to do if they suspected a person was at risk or suffering any type of abuse. One member of staff when asked thought that safeguarding referred to when people may abuse staff. Another member of staff told us that they would refer any safeguarding concerns to the GP and wasn't able to tell us who the lead safeguarding agency was. We found from one person's records that the person had alleged that they had been 'dropped' by a member of staff whilst moving them which had resulted in a bruise on their buttock. However this had not been reported appropriately to the manager as a safeguarding incident. We did feed this back to the manager who told us that they were looking into this.

As people were not always protected from the risk of abuse and improper treatment this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff did say that they would refer their concerns to the manager and if necessary to someone more senior. There was a Safeguarding Adults policy and staff had received training regarding this.

People said that they understood what medicines they were receiving. We looked at medicines management and administration at the service. The temperature of the medicines room and fridge was recorded daily to ensure that medicines were kept at the correct temperature. The provider had an efficient system of ordering new stock and had not over stocked on any product. The service medicines policy was comprehensive and up to date and staff knew how to access this. We observed a nurse undertaking the medicines rounds at the service.

We found that a lot of people living at the service had been prescribed Paracetamol (and other medicines) 'As necessary' (PRN) and there were guidance in place for each of these. People's Medicine's Administration Charts (MARs) were complete and up to date.

Risks were not always managed appropriately for people around concerns that had been identified. For example, one person was at high risk of developing pressure sores. No care plan had been developed to alert staff on what steps needed to be taken to reduce the risk of sores. Another person was at risk of malnutrition, the risk assessment around this had not been completed for more than a month. Another person had diabetes, they was no emergency equipment available in the event that this person become unwell.

Accidents and incidents were not always recorded. We identified there were two occasions where people had

Requires improvement

Is the service safe?

been injured as a result of an incident or accident. Although these had been written about in people's daily notes these had not been recorded in the incident recording book. The manager told us that this should have been recorded and would address this with staff. This meant that there was a risk that staff at the service were not analysing all the incidents to identify any trends or minimise reoccurrences

As people risks were not always been managed appropriately this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risk assessments for people were detailed and informative and included measures that had been introduced to reduce the risk of harm. This included management of manual handling, personal care and continence management. Risk assessments were also in place for identified risks which included malnutrition and choking and action to be followed. There was guidance to staff on the risks and what they needed to do to support this person. These risk assessments were assessed monthly and sooner if this was needed.

In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and made them safe. There were personal evacuation plans for each person that were updated regularly which was kept in people's files and a copy in the reception. These were used to provide staff information around how to support an individual in the event of an emergency

Staff recruitment files contained a check list of documents that had been obtained before each person started work. We saw that the documents included records of any cautions or conviction, evidence of their conduct in the previous employment, evidence of the person's identity and full employment history. It was confirmed by staff that all nurses at the service provided evidence of their professional registration. This gave assurances to the registered manager that only suitably qualified staff were recruited.

Requires improvement

Is the service effective?

Our findings

Staff were not always informed about their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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. We were told by the manager that most people had capacity at the service to make decisions. However there was not enough evidence from the mental capacity assessments carried out to confirm this.

There was one person who we were told by staff did not have capacity. We saw that this person had bed rails. There was no evidence of the best interest decision around this to record why it was in someone's best interest to restrict them of their liberty or who consented to the use of the bed rails. Staff did not always have an understanding of MCA or DoLS. One member of staff said that they didn't know what the terms meant and that they had not had training. This meant that people may be receiving treatment that they had not consented to or may have their freedom unlawfully restricted.

As there were not always effective systems in place to ensure that capacity was assessed and DoLs applied for where necessary this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were staff that did have an understanding of MCA and DoLs. They gave examples of where they would ask people for consent in relation to providing care. People said that staff asked them consent. We saw examples of this during the day.

Staff were not kept up to date with the required service mandatory training and there was a risk that people were not receiving the most appropriate care. The manager provided us with a training 'tracker'. This identified that whilst staff were up to date with some training (including food safety, moving and handling and food and nutrition) there were gaps in other areas. For example no staff had received falls training, fire drill training and emergency first aid. The clinical training 'tracker' identified that five nurses had not had updated training in skin integrity, wound care and nutrition. This was reflective in some of the records of care for people. Wound care and nutritional care recording was not reflective of the care that needed to be provided. One person was at risk of malnutrition. They had lost weight and staff were unable to tell us if they had been referred to a health care professional to address this.

Staff were not always supported in relation to the work that they carried out. There were no effective systems in place for staff to meet with their manager on a one to one basis despite the service policy stating that these needed to take place. The manager told us that they knew they were behind with staff supervisions. We saw from the 'tracker' that gaps had been identified and the manager was working towards these. Staff were not having the opportunity to regularly discuss any training needs and objectives. This is also the opportunity for the manager to discuss and feedback on staff's work performance and development. . One member of staff told us that since starting at the service this year they had not had supervision with their manager.

As staff were not always sufficiently trained or supported in their role this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported in their roles. One member of staff said that her induction was thorough and had undergone two weeks of shadowing an experienced member of staff before they started work.

People's nutritional risks were not always being monitored appropriately. We noted that in one person's care plan it had been identified that they had lost weight in July 2015 and that this needed to be monitored and referred to a health care professional. The person was still continuing to lose weight. Staff told us that this had not been followed up. Another person had been referred to the Speech and Language Therapist team (SALT) on 17 August 2015 as they were at risk of choking but this had not been followed up. This meant that people were not always accessing health care professionals in a timely way. On the day of the inspection we found that people in their rooms had to wait nearly an hour before they were provided with their lunch. However people did have access to other health care professional such as the GP and physiotherapist.

Requires improvement

Is the service effective?

As people risks were not always been managed appropriately this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of food and nutrition were good. Everyone we spoke with said that they enjoyed the food at the service. Comments from people included “The chef is great, they would do anything for me” and “The food is lovely, we have choices every day.” People had a choice of where to have their meals, either in the dining room or their own room. A menu was displayed on the tables in the dining room for people and on the wall outside. People were offered drinks and snacks throughout the day.

We observed lunch being served, we saw that staff engaged with people, offered choices and provided support to eat their meal if needed. There was a relaxed and chatty atmosphere. The chef had records of people’s individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently. Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs.

Requires improvement

Is the service caring?

Our findings

People and relatives felt that staff were kind and caring. Comments included "I'm well looked after here", "Staff are lovely", "They are kind and friendly" and "Staff seem to care about me, they check I have washed and help me with my clothes." One relative told us that staff were very good and very caring.

Despite these comments there were occasions during the inspection where staff were not as caring as they could have been. One person was being transferred from their bed into a wheelchair by two members of staff. One member of staff was advising the other member of staff what care needed to be given. They were talking over the person without including them in the conversation. One member of staff was heard saying in front of the person to another member of staff "Does she always have this on (referring to the persons clothing protector)?" and "Okay, do you want me to take her downstairs?" During lunch one member of staff was standing between two people and supporting them both to eat rather than sitting with the person and supporting one person at a time.

There were also times were staff didn't treat people with dignity and respect. One person's commode had been left in their room without it being emptied. The person told us that they didn't find this dignified especially if family had come to visit them. We pointed this out to staff who immediately addressed it.

As staff did not always treat people in a caring and dignified way this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However we observed some kind and caring interactions with staff and people. One member of staff was overheard chatting to a person over lunch. They asked the person how they were, they talked about the weather and whether they were enjoying the lunch. Another member of staff laughed and joked with people who clearly enjoyed the interactions. There were warm and friendly exchanges between staff and people. We saw staff knock on people's bedroom doors and wait for a response before entering their room. We saw that visitors were always welcome to the service.

Staff had good knowledge of individuals and knew what their likes and dislikes were. We found evidence of this when people were offered drinks throughout the day. Staff used people's preferred names when they spoke with them. Staff said that they enjoyed working at the service. One said "I would always ensure that people were treated with dignity." Another member of staff said "I would treat people as you would expect to treat your own mum." One health care professional told us that staff ensured that people's eye glasses were always clean and found the staff to be caring.

People and relatives said they felt involved in the planning of their care. One person told us that they were very much involved and they also chose to have their family involved as well. They said that they were asked what they wanted and what their preferences were. Staff knew this person well and understood their individual needs around how they wanted to live their life. Staff at the service used an advocacy service where people needed support, but currently all of the people at the service were supported by family members.

Requires improvement

Is the service responsive?

Our findings

People's records did not always include sufficient information to enable staff to provide appropriate care and support. We identified from three people's care plans that they had complained of pain. No pain assessment charts had been completed for any of these people to identify what the level of pain was. In one person's care plan there was no detail around the care and support needed for someone with their healthcare condition.

Another person had a history of urine infections. According to the care plan they last had their catheter changed on 5 July 2015 and that it should be done monthly, however it had not been changed since then. Another person required monthly observations according to their care plan however the last time this had been done was on 5 July 2015. These observations were needed to establish any changes in the person's health and included blood pressure check and temperature checks. This meant that people' care and support needs were not being met to their maintain well-being.

One person was at risk of pressure sores. Their care plan stated that they required pressure relieving equipment. The person was not provided with any pressure relieving cushion to sit on whilst out of bed. We found that all of the pressure relieving cushions in the service were not working and would provide no relief to the person. We raised this with the manager who said that they were going to address this and order new cushions.

Whilst we were at the inspection we identified that one person the previous night had discomfort with their catheter and was experiencing pain. The member of staff noted that they were unable to find the necessary equipment to flush through the catheter to relieve the discomfort and instead changed the person's catheter. This is a more intrusive procedure which can also increase risks of infection. We found that the member of staff had not been told that there was the equipment needed to flush through the catheter, this mean that the procedure to remove it had been unnecessary.

Communication was not always shared effectively between staff about people's needs. There was a staff handover after each shift where any information about changes in people's needs. However we established that information had not been shared about the missing piece of equipment needed to flush out the person's catheter with the oncoming nurse. We found out from the oncoming nurse that the equipment needed was available but had been stored in a different room. This could have prevented the person having to have their catheter replaced. We also found that where a bruise had been identified on one person this had not been shared at handover with staff.

There was a strong smell of urine coming from one person's room. The manager told us that they were looking to replace the flooring in this room to help reduce this. There was no evidence that this had been addressed or when it would be addressed.

Care and treatment was not always provided that met people's individual needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that before they moved in the manager undertook a pre-assessment of their needs. One person told us that they were visited at home by the manager (with their family present) to assess their needs. The manager told us that within 24 hours a care plan would need to be written for any new person being admitted. We found that pre-admission assessments were in each care plan and were detailed. Information included people's medical history, likes, dislikes and any potential risks to the person.

There was a complaints procedure in place for people to access. One person said "If I wanted to complain I would tell the care assistant or the manager." A copy of the policy was on display in the reception area for people to access. We reviewed the complaints log and noted that one complaint had been logged since the last inspection. One person wanted their nails to be cut which was addressed by the manager straight away. The manager told us that once a concern is raised they will deal with this straight away before it escalates into a complaint. There was a file of compliments from people. Comments included "Your care and kindness was much appreciated" and "The staff have gone out of their way to make (my family member) feel at home and comfortable and included."

People and relatives were complimentary of the activities that were on offer. One person said "The activities are great." Another person told us that they were exhausted

Requires improvement

Is the service responsive?

from all of the fun they had had that day. One relative had written in to say "Thank you for 'Tea at the Ritz' you hosted Friday. It made us all think we were actually at the Ritz and had a lovely time."

There was a wide range of activities on offer for people which included room visits for people, hand bells, musical workshops, manicures and crosswords. On the day of the inspection we saw people took part in a quiz, did armchair exercises and then enjoyed playing bingo with children who visited from the local school. We saw relatives visit and access the gardens with their families.

There were seasonal and themed events that took place throughout the year for example the village fete took place at the service. There were also religious services that took place in the service for people that wanted to attend them.

However people told us that they would like to go out more on day trips but that this wasn't always possible due to the service not having a vehicle. They said that taxis were expensive and that this reduced the amount of trips there were able to go on. The manager told us that they had asked the provider to supply a vehicle to enable people to go out more. This still had not been addressed.

Requires improvement

Is the service well-led?

Our findings

We found that not all of the records at the service were accurate and complete for each person. The care plans did not always detail exactly what care had taken place or detail the correct care. For example it stated in one person's care plan that they had a pressure sore. We couldn't see how this had been addressed. However on discussions with staff it was established that this was not a pressure sore and the recording of this was incorrect. It was recorded that another person had swelling to their wrist, there was no information in the care plan around how this had been addressed. We were told that a GP had assessed this injury however the GP notes of this had been kept separate to the care plan.

Another care plan stated that one person required neurological observations (usual for a person who has sustained a head injury) in the past. There was no record of any such injury and staff were unable to say why these observations had taken place. There was a risk that any health care professional or member of staff reading this were provided with the wrong information about people.

There were no effective systems in place to ensure the quality of the service. The regional team undertook a monthly 'Provider Review' audit of the service. This had identified that the quality of the documentation was 'Well done'. However we found on the day of the inspection that this wasn't always the case. It had been identified in July 2015 that supervisions for staff needed to be improved however these were still not up to date. The 'Quality Metrics' used to ascertain how many people had pressure ulcers or had suffered an injury or fall were not accurate because not all staff were recording these appropriately.

Surveys were undertaken to establish the views of people using the service. However comments made on the service provided were not always addressed. Where concerns had been addressed these were not recorded. The manager told us that there were no negatives comments about the service on the surveys. We looked at a sample and established that people had identified areas for improvement. One person asked if the chiropodist could attend to them in their room instead of the communal area. The manager said that this had been addressed but there was no record of when and how. Other people had raised concerns about having to wait for staff which had not been addressed. There were positive comments from the survey about the staff and the food.

Meetings had been held with people who used the service and their relatives. However these had not always been used as a way of improving the service. In June 2015 concerns had been raised by people and their family members around the times people had to wait for staff in the evenings. They also raised that they would like to be able to go on more outings. We found that these concerns were still being raised by people. The manager did not address these concerns in the meeting held in September 2015.

As there were no effective systems in place to assess and monitor the service to make improvements this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager shared information with people about changes at the service, such as changes to the staff and discussions around the use of agency staff. People who used the service and relatives said the management of the service was good. One person said "I see the manager around, she pops in to see me from time to time."

Staff told us that they felt supported by the manager. One said "I find her very approachable, everyone gets on well here." Another said that they felt listened to. They said "The manager knows people very well and she is approachable."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 **The registered provider had not ensured that care and treatment was always provided that met people's individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not always ensured that people were treated with dignity and respect.**

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 **The registered provider had not always ensured that staff acted in accordance with the requirements of the Mental Capacity Act 2005.**

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 **The registered provider had not always ensured that people always received safe care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The registered provider had not always ensured that people were protected from the risk of abuse and improper treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not always ensured that the quality of the service was assessed and monitored. The registered provider had not ensured the maintenance of accurate, complete and contemporaneous records.

Regulated activity	Regulation
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 The registered provider had not always ensured that sufficient numbers of qualified, competent and experienced staff were deployed. The registered provider had not ensured persons employed were always appropriately trained or supported