Rosemary Lodge Rest Home Ltd

Rosemary Lodge Rest 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 5 and 8 January 2015 and was unannounced. At the last inspection on 18 April 2013 we found that the provider was meeting the requirements of the regulations we looked at.

The home provides care and accommodation for up to 29 older people, some of who were living with dementia or have additional mental health needs. Nursing care is not provided. The accommodation is provided in both single and shared bedrooms. On the day of our inspection there were 25 people living at the home.

A manager was registered with us but they had not been employed by the provider since April 2014 and so were no longer managing the home. 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 a new manager in post but they had not applied to register with us.

People were supported by staff who had received training on how to protect people from abuse. Safeguarding procedures were in place but the provider had previously

Summary of findings

investigated an allegation against a member of staff without first informing the local authority as required. The provider told us they had learned from this and would ensure that in future the appropriate authorities would be informed of any allegations related to safeguarding people.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We looked at whether the service was applying the DoLS appropriately. Staff did not fully understand their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) but action was in progress to address this and ensure that staff received the necessary training to improve their understanding.

We saw that appropriate pre-employment checks had been carried out for new members of staff. These checks are important and ensure as far as possible that only people with the appropriate skills, experience and character are employed.

Improvement was needed to the staffing arrangements to make sure there were enough staff to meet people's needs. The provider and manager told us that they had recently agreed that an additional cook, laundry assistant and two care staff were required. We were informed that recruitment to these positions was underway.

Risk was assessed but management plans were not always detailed enough. This meant that people were not always properly protected from harm. Care provided was mainly centred on providing for people's personal care needs. There was a lack of consistent planning of a programme of activities and stimulation that was relevant and tailored to meet the individual needs of people.

During our inspection we received some negative comments about the environment. We were informed by the provider that some of the communal areas had recently been repainted and that further improvements were planned for 2015.

Staff showed kindness and compassion to people who used the service. However, people's privacy and dignity had not always been protected.

People's nutritional and dietary needs were assessed and people were supported to eat and drink sufficient amounts to maintain their health. People had access to healthcare professionals when this was required.

People knew how to raise complaints and the provider had arrangements in place so that people were listened to and action could be taken to make any necessary improvements.

We found that whilst there were systems in place to monitor and improve the quality of the service provided, these were not always effective. We found that the systems in place had not identified some areas that required improvement that had a direct impact on people using the service or placed them at risk of receiving inappropriate care. The arrangements in place did not comply with the law. You can see what action we told the provider to take at the back of the full version 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?
The service was not consistently safe.

People were not always appropriately protected from risk of avoidable harm.

Arrangements for the identification and referral of safeguarding concerns had not been clear.

We were not assured that there was always sufficient numbers of staff available to meet people's individual needs.

Some aspects medicines management were not safe.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Due to a lack of understanding by staff of the Mental Capacity Act 2005 we could not be confident that they would always act in people's best interests and training had been due to be provided just after the inspection.

People were supported to have enough to eat and drink and were supported to maintain their health.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People were positive about the care they received. Staff showed kindness and compassion to people who used the service. However, people's privacy and dignity had not always been protected.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People were not always having their needs appropriately assessed and the care related to their needs was not properly planned for.

People had limited support to follow their interests and hobbies.

People knew how to raise complaints and the provider had arrangements in place so that people were listened to and action could be taken to make any necessary improvements.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

Requires Improvement

Summary of findings

Whilst there were arrangements in place to check the safety and quality of some aspects of care further improvements were needed. The providers monitoring and management of staff practices and of the care people received was not robust and had failed to ensure that people were protected from the risk of their needs not being met.

A requirement of the provider's registration is that they have a registered manager. The registered manager had left in April 2014.

People's and visitor's opinions were sought by the provider to help develop and improve the service provided to people.

Rosemary Lodge Rest 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 inspection took place on 5 and 8 January 2015 and was unannounced. It was undertaken by two inspectors.

We looked at the information we held about the service prior to the inspection. We looked at information received from relatives, from the local authority commissioner and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

During our inspection we spoke with 10 people who lived at the home. Some people's needs meant that they were unable to verbally tell us how they found living at the home. We observed how staff supported people throughout the day. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two health care professionals, the relative of two people who lived at the home, the provider, the manager, two cooks and three care staff. We looked at the care records of four people, we looked at the medicine management processes and at records maintained by the home about staffing, training and monitoring the quality of the service.

Following our inspection the provider sent us further information which included the audits they had carried out to check the standards of the services people received and further evidence of the training staff had completed. This information was used to support our judgment.

Is the service safe?

Our findings

People who lived in the home told us that they felt safe living there. Comments from people included, "I am not frightened here, it's nice" and, "Of course I feel safe." Relatives of people who lived in the home told us that they thought people were safe but we were told that sometimes people were frightened when people came into their bedroom. We spoke with the provider who told us they had not been aware of this. They agreed they would follow up on these concerns to establish if this referred to members of staff or other people who lived at the home.

Staff told us they had received recent training in safeguarding vulnerable adults and records confirmed this. Staff were able to tell us how they would respond to allegations or incidents of abuse. Staff told us that people were safe, comments from staff included, "It's good here, we work as a team. The residents are safe, we report anything to a senior straight away." And, "If I had a relative I'd have them placed here."

Safeguarding procedures were in place but the provider had investigated an allegation against a member of staff without first informing the local authority as required. The provider told us they had learned from this and would ensure that in future the appropriate authorities would be informed of any allegations of a safeguarding nature.

The systems to ensure the safe administration of medicines in the service were not sufficiently robust to ensure people who used the service were adequately protected. Medications that required cool storage were kept in a refrigerator. Records were not available to show that the temperature of the refrigerator had been regularly checked. We raised this with the manager who told us they had not been aware of the need to monitor and record the temperature of the fridge. A failure to store medicines at the correct temperature could mean that they would not be effective to treat the conditions they were prescribed for.

Some people using the service had medications that they took only when required. One person was prescribed medication at a variable dose, this meant that staff could administer either one or two tablets as required. Staff had often not recorded on the medication record how many tablets had been administered. Individual plans of care of people who had 'as required' medicines did not detail when and how these medicines should be given. This meant there was a risk that people might not receive the medicines that they needed or that they would be given them at the wrong times.

Staff told us they had received training to administer medication and records supported this. We observed two staff supporting people with their morning medicines. They spoke to people about their medicines, offered appropriate drinks and ensured that the medicine was taken. One person was on medication on a short term basis as they were currently unwell. We checked their medication record and the quantity of medication held in the home, this indicated that the person was receiving their medication as prescribed.

During our inspection we observed staff assisting people to move from chairs into wheel chairs and vice versa. This was completed safely and people were not rushed by the staff assisting them.

Some people at the home were at risk of falls. We looked at one person's care records and found a lack of detail to show how the risk of falls was assessed and managed. Their care records also had conflicting information about the support they needed. Whilst the manager told us that a falls alert sensor mat had been used the person had experienced a fall since admission that had resulted in an injury. The provider told us that following this reported accident they had read the written accident record book, night staff observation book and daily logs however there was no formal investigation report or evidence that learning had taken place.

The majority of people who lived at the home told us there were enough staff to meet their needs. One person told us, "Staff always answer the buzzer, I've no problems with getting help from the staff." A relative of a person commented, "Sometimes they are a bit short staffed. I have no problem with the staff, but they do get tired." We spoke with two health care professionals and neither raised any concerns about staffing levels. Our observations showed that a member of staff was available in the communal lounge and dining areas at all times and people received support with their personal care needs when required.

Staff we spoke with did not think that staffing levels were unsafe but we did receive some comments that staffing could be improved. One member of staff told us, "I think there is enough staff, the shift is always covered." We

Is the service safe?

looked at the staffing roster for December 2014. This showed that some staff sometimes worked a late shift followed by a night shift. Working long hours without adequate rest periods means there is a risk that staff will become tired and may not provide safe, effective care.

We spoke to the provider about how the numbers of staff were determined. We were informed that staffing levels were based on the needs of people at the home but that a formal assessment of staffing requirements had not been completed. The provider and manager told us that they had recently agreed that an additional cook, laundry assistant and two care staff were required. We were informed that recruitment to these positions was underway and improvement was planned for.

Staff told us that they had been interviewed and checks had been made before they were employed. We looked at the recruitment records for a recently recruited member of staff. We saw that appropriate pre-employment checks had been carried out. These checks are important and ensure as far as possible that only people with the appropriate skills, experience and character are employed.

Requires Improvement

Is the service effective?

Our findings

We asked staff about their induction, training and development at the service to see whether staff had the appropriate skills to meet the needs of people who used the service. Staff told us that they had received an induction, had on-going training and regular supervision. One member of staff told us, "I have enough training, I have my NVQ 3 and we do refreshers such as safeguarding and infection control." We reviewed the provider's training records and saw that relevant training was provided to help ensure staff had the skills and knowledge to provide care which met people's specific needs.

During our inspection we observed staff seeking consent from people regarding their every day care needs. Staff told us that one person sometimes refused personal care and certain health checks. The manager had consulted the person's social worker and a best interests meeting had been arranged to discuss how staff could meet this person's needs.

We looked at whether the provider was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. Some people who used the service had not had mental capacity assessments and the care some people received had not been reviewed to identify if a DoLS application was required. We saw that the front door was subject to a scanned locking system and during our visit one person indicated they wished to leave the home. The manager had made one recent application for a DoLS authorisation and told us they had discussed with the local authority making an application for a second person. We found staff did not fully understand their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider had already taken action to address this and training was scheduled to take place a few weeks after our inspection.

We checked to see whether people were protected from the risks of inadequate nutrition and dehydration and found that they were. The majority of people who used the service told us they liked the food choices and everyone told us that they had plenty to eat and drink. One person told us, "The meals are all fine, we get a choice." Another person told us, "The food is good and I get plenty of drinks." Relatives we spoke with were complimentary about the food provided. One relative told us, "[Person's name] is a fussy eater, they have done wonders here and [person's name] is eating much better than before." A member of staff told us, "People are well looked after here, if there's a problem with a diet we get a dietician, some people are on soft diets and there is always a choice. They get big meals and extras as well if they want."

The provider employed a full time cook and a part time cook. Our discussions with one of the cooks indicated they were not confident in their role and may not have had the necessary skills to perform their duties effectively. A recent visit had taken place by an environmental health officer who had informed the provider that staffing arrangements in the kitchen were under- resourced given the number of meals produced each week.

We observed a mealtime in the dining room during our inspection. Staff appropriately supported people who needed assistance to cut up their food, or who needed assistance to eat their meal.

Some people were provided with plate guards to help them eat their own meals without assistance from staff. People were offered extra portions and were offered a choice of drinks with their meal. People were offered regular drinks throughout our inspection. We spoke with three people who were spending time in their bedroom. Two people had drinks that they could help themselves to, but one person had an empty glass and there was no jug of water provided. This was rectified when we brought this to the attention of the manager.

In the kitchen we saw a four week rolling menu plan and a list of each person's likes and dislikes. The cook had a clear understanding of people that needed supplements in their diet or needed a soft diet. When speaking with staff about the needs of one person we received conflicting information about the texture of the food they required. Staff had completed nutritional risk assessments and people had been weighed regularly as required. Fluid and food intake charts had been completed for people assessed as being at risk of poor nutrition or dehydration. We found examples when these records had not been completed fully enough. The lack of recording could have impacted on the monitoring of people's healthcare needs and delayed appropriate action taken to respond to any

Requires Improvement

Is the service effective?

changes. We saw that the provider was taking action to improve staff knowledge regarding nutrition and hydration. Training in this area had been scheduled for the week after our inspection.

We looked at how people's health needs were met. We spoke with two GP's who were visiting people during our inspection. Neither raised concerns about how staff were currently responding to people's health care needs. One GP commented that there had been concerns in the past but that improvements had been made. They told us that the staff did not delay in contacting them when people were unwell. One person told us "They always get the doctor if I am not well." A relative of a person at the home told us, "When needed, they get a doctor in straight away." Records showed that staff had taken action when there were concerns about the health of any of the people who used the service. For example, GP's had been called out for two people who were unwell. Records showed when appointments had been made and what advice had been given by medical professionals.

During our inspection we received some negative comments about the environment. A relative told us, "The toilets and bathrooms need a facelift, they are clean, but I'd only give them five out of ten." A health care professional also told us that they would not want their relative to live at the home due to the standard of the environment. We therefore looked at whether people's needs were met and enhanced by the design and decoration of the home.

On the morning of the first day of our inspection we went into a large lounge area that was not being used by people. The room was unheated and cold. A person who lived at the home told us, "I never sit in there, it's cold, I've never seen anyone in there." We brought this to the attention of the manager and the provider. They told us that they had not been aware that the room was cold but that it had not impacted on people as they preferred to use the other lounge. We saw that later in the day the room was a comfortable temperature and this was also the case on the second day of our inspection.

We looked at the communal areas of the building and saw that the carpets in the upstairs areas were very stained. We were provided with evidence that new carpets had been scheduled to be fitted in January 2015. We saw that some areas of the home were worn and may benefit from redecoration and that a schedule was in place to address this. We were informed that repainting of toilets and bathrooms would take place in early 2015. During our inspection we brought to the manager's attention the fact that it had taken four minutes to get hot water from the tap at a hand basin in one of the toilets. Following our inspection we were informed by the provider that a decision had been made to fully refurbish a first floor bathroom, with the possibility of creating a wet room.

We saw that limited adaptations had been made to the design of the home to support people with dementia. **We recommend that the provider considers the National Institute for Health and Care Excellence Quality standard for supporting people to live well with dementia.**

Requires Improvement

Is the service caring?

Our findings

We observed positive interaction between staff and people who used the service and saw people were relaxed with staff and confident to approach them for support. People who lived at the home told us that staff was caring. One person told us, "I have no complaints, I'm pleased with the staff. They do what I need. If I need something they help me. The staff are really nice." Another person told us, "I cannot fault the place, I would give it 10 out of 10. The staff are all great and never let me down." People who lived at the home and their relatives told us that visitors were made welcome. One person told us, "My daughter can visit when she wants."

Whilst spending time with people in the home we saw that one person did not receive the support they needed from staff to make sure they were sitting comfortably in their chair. The person was slumped in their chair and looked uncomfortable for a period of an hour and five minutes. Several staff walked by the person but did not take any action such as asking the person if they would like to be helped into a more comfortable position. After we intervened staff provided support and with the agreement of the person they provided them with a cushion and helped them into comfortable position in their chair.

We saw people being supported with kindness and consideration. Staff spoke with people in a kind manner and knew them well. We saw at lunchtime that staff helped people to eat at a pace that was suitable for them. People were helped into and out of chairs calmly and with dignity. During the morning a person asked for a glass of milk and we saw that it was given straight away.

A relative told us that the person they were visiting were wearing someone else's trousers. We also observed one person was wearing very ill-fitting clothes that failed to promote their dignity, and we saw that no member of staff attempted to support the person to change their clothing . When we brought this to the manager's attention they told us they did not know why the person was wearing trousers that were too short as they had other suitable clothing available.

We saw that people were provided with suitable equipment in order to maintain their dignity. These included mobility aids, crockery and cutlery which enabled them to be as independent as possible. We saw that staff did not enter people's rooms without knocking first. However, we found in some instances people's privacy and dignity was not promoted. We noted people wearing clothing that did not fit properly with no evidence that staff had tried to support people to choose clothing that fitted.

On the first day of our inspection we noted that one of the toilets did not have a lock fitted to the door. The manager told us this had been reported as requiring repair. When we visited three days later we found this had not been repaired. This demonstrated that action had not been taken to consider and protect the privacy and dignity of people.

Some people at the home shared a bedroom. This may sometimes make it difficult for people to have the level of privacy they may prefer. The provider had made some arrangements to provide some privacy by having fixed dividing walls installed within these bedrooms. Two people we spoke with who shared a bedroom did not raise any concerns about these arrangements.

It was evident from the staff we spoke with that they knew the people who used the service well and had learned their likes and dislikes. However, some care staff told us that they were not always able to facilitate interests people wanted to pursue because most of their time was taken up in the provision of personal care.

We saw that there were some arrangements in place for people to be involved in making decisions. Monthly group meetings were held with people at the home where they were informed and consulted about some aspects of the running of the home. For example, we saw that people had been consulted about the colour scheme when repainting of the lounge and dining room had taken place.

Some people at the home were unable to voice their opinions about their care due to their dementia or mental health and did not have any relative involvement to speak up on their behalf. The provider had recently sought advocacy input on behalf of these individuals but had so far been unsuccessful in obtaining these services.

We found that confidentiality at the home was not always maintained. During a medication round we heard a member of staff discuss a confidential health matter with a person in a communal area. We also found that a review was needed of the security arrangements for people's

Requires Improvement

Is the service caring?

confidential care records as we found the cupboards and office used to store them were not locked and were sometimes left unattended. This showed a lack of respect for the people's personal information.

Requires Improvement

Is the service responsive?

Our findings

People told us and records showed that activities had been arranged over the Christmas period that people had enjoyed. However we were made aware that the activities usually offered to people suited their individual preferences and interests. One person told us, "We just hang around really." A relative of a person at the home told us, "They used to have a singer and an exercise instructor, but I haven't seen them for a few months." During our inspection some people were playing board games with staff but other people spent much of their time sleeping or watching television with very little interaction from staff other than to respond to their personal care needs.

We spoke with staff about the arrangements for people to participate in leisure interests and hobbies. One member of staff told us, "We have activities here, there's painting and baking and games. We have one or two activities a week." One staff told us, "I think people lose out on activities." Another staff member told us that they included activities when they could but most of their time was devoted to other care tasks. From what people told us and our observations we found that hobbies and interests were not routinely planned to give people a quality of life and to maintain their individual interests.

We looked at the arrangements in place to assess people's needs prior to their admission into the home. One person's assessment showed they had a history of falls prior to moving in. Their assessment did not contain any significant detail about the previous falls and did not evidence that either the person or their relative had contributed to the assessment. The lack of information in the assessment made it difficult to see how the provider had determined that they were able to meet this person's needs. Following admission the person had experienced some falls. Action had been taken to discuss the person's needs with their relative and we were informed it was intended to discuss the person's placement with their social worker. However we noted that the person's risk assessment or care plan had not been reviewed to show how the risk was currently being managed.

We looked at the care records for one person who had a history of refusing support with personal care. The records did not detail the person's behaviours, their possible trigger that made them anxious or how staff were advised to support the person to keep the person safe and well. We spoke with staff who told us how they responded to the person to help reduce their anxieties. This information showed they knew the person well but it was not included in the person's care plan. This meant there was a risk that staff responded in an inconsistent manner. We spoke with the manager about how staff were meeting this person's needs. The manager told us that a review meeting had already been scheduled with the social worker and following this they would update the care plan. Because the information on how to respond to the person was not available to staff this meant behaviours might be managed inconsistently.

Records showed that most people's care plans were reviewed on a monthly basis. However, the record of the review undertaken lacked detail and there was no evidence that people were involved in their review of their care and support needs. This placed people at risk of not receiving care and support the way they like and showed us that the provider had not involved them.

We asked people and their relatives how they would complain about the care if they needed to. People who lived at the home were aware they could tell staff if they were unhappy. A relative of a person at the home told us, "The managers are approachable and I'd just talk to them if there was a problem. The managers tell me what's going on." One relative told us they had raised a concern a few weeks previously but had not yet received a response. We raised this with the manager and the provider. They told us they had not been aware of the concern raised and agreed to investigate.

Records showed that at monthly group meetings people who lived at the home were asked if they had any concerns or complaints they wanted to raise. We saw there was a system in place to record complaints received. The complaints log showed that in the last 12 months, six complaints had been received and investigated. We looked at the response to three complaints. The manager had acted on the complaints raised and people had been informed of the outcome and actions taken. This showed they were used as an opportunity to improve the service that people received.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor and improve the quality of the service provided, however we found that these were not always effective. Records were kept of complaints, accidents and incidents that occurred. There was a lack of robust analysis by the provider to identify any patterns or trends. Identification of patterns or trends would give the provider information about whether processes or procedures needed to be changed, or care plans needed to be updated to reduce the risk of a reoccurrence of events occurring.

A number of audits had been completed by staff at the home and by a representative of the provider. These included audits of the environment, medication and care records. However, these had failed to identify the shortfalls we found relating to medication records and reassessments when people's needs changed. We were informed that the provider visited the home on a weekly basis and spoke with staff and people who lived there. The provider told us that they did not make any record of their informal checks or of the outcome of these visits. The arrangements for the monitoring and management of the home needed to be improved as they did not always ensure that day to day risks and performance issues were identified and action implemented to improve the quality of the service provided to ensure that people were protected from the risk of inappropriate care.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had developed opportunities to enable people that used the service and relatives to share any issues or concerns. Meetings were held with people and their relatives and the manager had conducted a survey in April 2014 to seek people's views. This showed that overall; people were satisfied with the service they received. Out of the 12 surveys received, three people had made suggestions for improvement. Each person had received a personal written response from the manager about the action taken in response to the suggestions made.

We saw that the provider had taken action to respond to the findings of an environmental health report regarding their food safety arrangements inspected by the local authority. The provider had previously been awarded a one out of five rating. Improvements made by the provider had resulted in a four out of five rating at the most recent inspection. This showed us that when concerns had been identified to the provider appropriate action had been taken to improve.

We found that there were not always clear lines of responsibility in regards to the management arrangement of the home. When we discussed with the manager that some staff were working excessively long hours without a break we were informed that the provider completed the staff rota. The manager did not seem to know why staff were working such long hours. When we asked the provider and manager about the assessment process for a new person at the home neither were able to satisfactorily answer our questions and said this was because a member of staff who worked elsewhere had completed the assessment.

Staff told us that they attended regular staff meetings and were given the opportunity to contribute to the development of the service. All staff we spoke with told us that the manager was approachable. One member of staff told us, "The manager is very supportive and is quick to act, she's a good leader." Another staff told us, "The manager gives brilliant advice, straight away and she responds really quickly, she is very supportive."

Throughout our day we saw the manager interacted with people who used the service, they were responsive, friendly and supportive in meeting people's needs. The manager told us that they usually worked alongside staff. The staff rota showed that the manager was usually part of the numbers of care staff on duty and so had little time specifically allocated for management tasks.

A requirement of the provider's registration is that they have a registered manager. We had been notified by the provider that the registered manager left in April 2014. The registered manager had not made an application to cancel their registration, this meant they were still registered to manage the home. The current manager had been employed for more than six months in their role but at the time of our inspection they had not submitted an application for registration with us. The provider informed us they would ensure an application to become registered was submitted.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements to regularly assess and monitor the quality of the service provided. Regulation 10 (1) (a). People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements to identify, assess and manage risks relating to the health and welfare of people who used the service. Regulation 10 (1) (b).