Interhaze Limited

Sebright House Care Home

Inspection report

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Date of inspection visit: To Be Confirmed
Date of publication: 18/03/2015

Ratings

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

Overall summary

The inspection took place on 7 January 2015. It was an unannounced inspection.

Sebright House is a nursing home providing care and accommodation for up to a maximum of 40 people. On the day of our inspection there were 31 people living in the home. There was one person who had been receiving respite care and was due to leave on the day of our visit.

People's rooms are situated on the ground and first floor of the building. There are three communal lounge areas and a conservatory on the ground floor. There is a lift for people to access the first floor rooms including the bathroom/shower rooms although the bathroom was not in use at the time of this visit.

The home has a registered manager. 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.

Summary of findings

The registered manager was not fully complying with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records we looked at showed there were concerns about people's capacity to make decisions. Although people had been assessed to determine how decisions could be made in their best interests, applications for DoLS were not always being made when they should be. We found two people were being deprived of their liberties without formal agreements in place which meant they were not meeting the requirements of the law.

We found the registered manager had not sent all the statutory notifications required to the Care Quality Commission relating to safeguarding people. These notifications inform us about incidents that affect the health, safety and welfare of people who live at the home.

People living at Sebright told us they felt safe. Care staff understood their responsibility to be observant at all times to keep people safe. They knew how to recognise abuse or poor practice and told us they would report abuse if they observed this happening. There was a risk assessment process in place to manage risks to people and help protect people from the risk of harm. This included plans for staff to follow in the event of an emergency such as a fire to make sure people were kept safe. These were not easily accessible to the emergency services if required.

People were provided with food that met their identified health needs. Some people needed to have their food and fluid intake monitored by staff due to their health condition. Records showed increased calorie diets were provided to those losing weight and at risk of poor nutrition.

People were supported to maintain their health and wellbeing through access to healthcare professionals. Care records and assessments contained detailed information to support staff in meeting people's needs in a way they preferred.

There were suitable numbers of trained staff on duty to meet people's needs. Everyone spoken with considered staff to be kind, caring and respectful towards them. We observed staff to be caring and supportive to people throughout our visit. We saw staff respecting people's privacy and dignity when providing their care such as when they supported people to transfer from a wheelchair to a chair.

Visitors spoken with said they felt listened to and would feel comfortable raising any concerns they may have with the registered manager or other staff members. The provider obtained feedback from people and their relatives about the service to identify where improvements were needed to the quality of service provision. The resulting actions to be taken were not always clearly communicated to people and their relatives so that they knew their issues had been taken seriously.

The provider carried out checks on the quality of care and services to identify areas that required improvement. Some of the areas identified for improvement have been ongoing for some time.

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?
The service was safe.

There were sufficient staff on duty to keep people safe within the home. Staff understood their role in keeping people safe and knew the action to take if they suspected abuse may be happening. Potential risks to people's health were assessed and care plans put in place to manage any identified risks. Medicines were administered as prescribed and were stored and disposed of safely.

Good

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

Where people did not have mental capacity and potential restrictions on people's liberty had been identified, applications had not always been made to the local authority under the Deprivation of Liberty Safeguards.

Staff had received training which provided them with the skills and knowledge needed to deliver effective care. People received the care and support necessary to manage their health care needs and were provided with a choice of food with their special dietary needs catered for.

Requires improvement

Is the service caring?
The service was caring.

Staff were caring and patient. People responded positively to the relaxed and friendly support from staff. Staff understood people's different communication needs so they could support them to make choices and maintain their independence.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed and care delivered in line with their own individual care plan. There were some planned activities provided to help support people's social care needs. Formal complaints were investigated and responded to so that where necessary improvements could be made.

Good

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

The registered manager had not sent us all the statutory notifications regarding safeguarding people to help us monitor that incidents were

Requires improvement

Summary of findings

appropriately managed. There was open communication between the manager and people who lived at the home, staff and visitors. Staff felt supported by the manager. Some of the actions required following quality monitoring of the service were not always acted upon promptly.

Sebright 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 inspection carried out by two inspectors, an expert by experience and a specialist advisor on 7 January 2015. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service. The expert-by-experience who supported us had experience of caring for someone with a diagnosis of dementia. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing and mental health.

Before our inspection we asked the provider to complete a Provider's 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 improvements they plan to make. They did not return a PIR as this was sent to an email address that had been changed and which we had not been informed of. We took this into account when we made the judgements in this report.

We reviewed the information we held about the service. We looked at information received from other agencies involved in people's care. We also looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with the local authority and asked them if they had information or concerns. They confirmed there were no ongoing concerns regarding this home.

The majority of people living at Sebright were not able to share their views and opinions about how they were cared for. This was because of their diagnosis of dementia and their difficulty in remembering and explaining detailed information about their care. To help us understand people's experience of the service 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 seven people who lived at Sebright and three relatives. We also spoke with four care staff, two nurses, the activity organiser, the National Vocational Qualification (NVQ) assessor, the cook, a maintenance person and the registered manager.

We looked at five people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records and social activity records. We also looked at the provider's quality monitoring records including quality audits, staff recruitment records, thank you cards, records of complaints, safeguarding records, incident and accidents at the home and maintenance/health and safety records.

Good

Is the service safe?

Our findings

People who lived at Sebright had nursing needs with many having a diagnosis of advanced dementia. This meant they could not always respond in detail to the questions we asked about their care. We asked people if they felt safe living at the home. One person told us, "Probably, I would tell someone if I felt unsafe."

We saw staff kept people safe from situations that could compromise their safety such as responding to people's behaviours that could cause harm to others. We saw that staff gently and effectively guided people away from potential confrontations and reassured them. Staff we spoke with were aware of those people that required closer observation and support. Risk assessments and management plans identified the specific techniques staff needed to use to minimise risk.

Where investigations had been necessary such as those in response to accidents, incidents or safeguarding alerts, the registered manager had completed an investigation to learn from these. The manager had recognised areas of risk and had made improvements as necessary. For example, she had organised one-to-one staff support when needed.

Most staff we spoke with demonstrated an understanding of their role in keeping people safe. They were aware that abuse could take different forms and told us they would report any concerns to the senior on duty or the manager. For example, two staff we spoke with told us, "If I see anybody abused by a member of staff, I would tell somebody. We have to log down everything that happens to the residents." "Everything is called abuse from making them get up when they don't want to, to not having freedom to live their own life. I would report it." The one member of staff who appeared unclear about different types of abuse was new to the home and had not completed training in safeguarding people. This staff member told us they always worked alongside another member of staff and would tell someone if they saw anything that concerned them.

Staff told us they thought there were enough staff to meet people's needs. Comments included: "Plenty." "We never work on our own, always with another carer." Staff also told us the staff levels at weekends remained the same so that people received a consistent level of support. We saw there were enough staff on duty to keep people safe. There were two nurses, one senior member of care staff and eight care staff. The manager told us the number of care staff would be increased to ten when the home was full. Staff always worked in pairs and there was always a staff presence in the communal areas such as the lounges and dining room. Where people had particular behaviours that were challenging to others, staff support was provided on a one-to-one basis.

We spoke with staff about how they were recruited to the home. Staff told us they had to wait for police and reference checks to be completed before they were able to start work. One staff member told us they had three interviews before they were offered the position of care worker. We checked the file of a newly recruited member of staff. This confirmed all the necessary checks had been undertaken by the registered manager to ensure the staff member was safe to work with people who lived in the home. The staff member told us, "She wouldn't let me start before the CRB (Criminal Records Bureau) check."

Risk assessments had been completed for people in areas where they had been identified to be at risk. For example, people at risk of developing skin damage. There were management plans in place informing staff of the action they needed to take to manage these risks. These actions included the use of pressure relieving equipment such as cushions and specialist mattresses to keep people safe. Care staff told us, "When we turn them over, we get told whether it is a one or two hourly check, we have to check on pressure relief." Hi-low beds were also in use which could be adjusted to a low level setting to help prevent people coming to harm should they fall out of bed. Risk assessments had been regularly reviewed and changes recorded to ensure risk was minimised and appropriately managed.

We spent time observing staff interactions with people. We saw staff assisted and guided people who were unsteady on their feet to chairs or helped to re-position them in chairs so they remained safe and comfortable. Staff used handling belts and other equipment when supporting people to make sure they were moved in a safe way. We saw each person had their own appropriately sized sling for use with the hoist.

We asked the registered manager what contingency plans were in place in the event of any unexpected emergencies that affected the delivery of service or put people at risk. For example, if there was a fire. The manager told us each

Good

Is the service safe?

person had a moving and handling care plan that showed if they could mobilise, and if not, how they would need to be supported to move to another area or exit the building. There was no central record for staff or emergency services to follow to ensure people were moved quickly to a place of safety. The registered manager said she would discuss this with the provider with a view to addressing this. Care staff told us they would be guided by the nurses as to what action to take at the time.

We looked at the management of medicines in the home. Medicines were stored securely and in accordance with the manufacturer's instructions so they remained effective. We saw the nurses safely administer and support people to take their medicine. Medicine administration records were complete and up-to-date to show people were receiving their medicines when they needed them. Each person had their own section in a medication administration folder with a photograph of them to reduce the chances of medicines being administered to the wrong person. Where it was necessary for people to be given medicine covertly (in disguise), we saw this had been agreed with the GP. We were told the GP reviewed people's medicines on a regular basis to make sure there was a need for people to continue to take them.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

Some people did not have the capacity to understand the risks of continually refusing support, for example, with personal care and assistance with eating. We saw mental capacity assessments in people's care plans identified those people who lacked capacity to make a decision. Although discussions had taken place with those closest to them, the detail of decisions made with them was not recorded to show their involvement and agreement.

Staff understood the need to gain people's consent before providing care and support. For example, one staff member told us, "Everybody is different and some people work well to praise. Generally you can talk your way round but if not try later or try a different face. Generally we leave them alone and then try and go back." Staff spoke about reading people's body language and facial expressions to ensure people consented to the support provided.

Staff told us they had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was to help them understand the need to make sure people who required assistance to make decisions received the appropriate support and were not subject to unauthorised restrictions in how they lived their lives. However, we saw that two people often tried to exit the building but could not because of a locked door. In the care file of one of these people it stated "[person] has a strong desire to go home and can't understand why he can't be with his wife." There was a risk assessment in place for exiting the building if the door was left open stating the person was at high risk. The DoLS assessment tool stated there were no restrictions on the person's liberty when these actions were doing so. The staff had not understood what a restriction was and had not acted appropriately and made referrals to ensure that the person was not lawfully restricted. When we spoke to the manager she said the care plan was not up-to date to reflect this should be in place.

This meant the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010.

We looked to see what arrangements were in place to manage 'Do Not Attempt Resuscitation' (DNAR) orders when people's health deteriorated. This was to make sure people's wishes were respected in terms of attempting resuscitation in the event of their deteriorating health. We saw a care file for one person which contained 'Do Not Attempt Resuscitation' (DNAR) documentation. The form had been signed by the registered nurse and the GP to confirm this would be an acceptable action in specific circumstances of ill health. The record confirmed the person's relatives had been consulted about this decision as the person had been assessed as not having capacity.

Three visitors we spoke with told us they felt staff had the skills and knowledge to provide the care people needed. We saw staff were very attentive towards people, making sure they were comfortable, had a drink or were assisted with their personal care when they needed. One visitor told us, "Staff seem to know the right approach to calm and handle residents often intervening and de-escalating certain situations." The visitor also stated staff were observant and responded to people's needs. Another visitor told us "I think they are very well trained."

Both nursing and care staff we spoke with told us they were supported to complete the training they needed to meet people's needs effectively. Staff had completed induction training when they started work at the service which included shadowing experienced staff to help them get to know people well and provide care in accordance with their needs and wishes.

The provider was committed to developing staff skills so they could carry out their roles effectively. One staff member we spoke with said they had completed training and said, "It is really good." Staff were observed to communicate and support people appropriately to maintain their needs. Staff were supported to gain further qualifications in health and social care to further develop their skills. Some staff had already obtained a National Vocational Qualification (NVQ) 2 in care and were completing their NVQ 3.

A training matrix showed staff completed training on an ongoing basis to help develop their care skills.

There were arrangements in place to ensure people received good food and sufficient to drink. We saw those people who could eat independently were able to eat when it suited them rather than at formalised times. The main

Requires improvement

Is the service effective?

meal was served at lunch time and there were choices of meals available. Those people who needed assistance to eat were supported in a caring manner and we saw they were given enough time to eat and drink at their own pace. Menus were available although these were not always followed to demonstrate people (including those on a pureed diet) had a range of choices on a regular basis. The manager told us there was always a choice of two meals for everyone.

Where people were identified to be a risk of poor nutrition, their food and fluid intake was being monitored. When staff became concerned about people's eating and drinking, we saw the advice of a Speech and Language Therapist (SALT) had been sought. The cook told us they were asked by nurses to provide high calorie milkshakes for those people who had lost weight. We saw records confirmed milkshakes were being given to a person who had lost weight in the previous month to help them increase their nutritional intake, gain weight and prevent their ill health.

We asked people about seeing health care professionals. A visitor we spoke with told us, "I changed the family doctor to the one here; he is pretty well on tap." Another stated, "I will give them that, if there is somebody they are concerned about, they are straight on to that (contacting the doctor)." Care files showed people's health care needs were addressed when needed by regular involvement of professionals.

Good

Is the service caring?

Our findings

People who lived at the home and relatives we spoke with told us all the staff were caring and kind. A relative we spoke with told us, "A smile and a cuddle can get them whatever they want, it doesn't matter what situation they are in." Another stated care staff were, "Very caring."

We saw staff smiled and were friendly in their approach to people and knew what to do if people became upset. For example, we saw one person walk into the manager's office crying, we saw the manager put an arm around them and offer reassuring words which calmed them. A staff member we spoke with told us, "We treat them like your family." It was clear that staff had formed caring relationships with the people they looked after. Support provided was low key with gentle interactions. Staff acknowledged people when they walked past them even though some could not respond. When staff attended to people's needs we saw them talking to people at a pace the person could understand to give them time to respond and communicate their needs. We saw staff provided comfort and support to people by holding people's hands or stroking their arms.

People told us they could make their own decisions and were able to make choices about their care. People told us, "I get up when I want to." "I've got no worries it's freedom."

Relatives we spoke with told us staff had communicated with them about their relative likes and dislikes. One relative told us, "If I tell them something they don't like (food), they are very good and don't give it to them." Staff knew that one person liked to be addressed by a specific name, we heard staff call them by their preferred name.

Staff told us they involved people in making day-to-day decisions about their care. One staff member told us, "If they want to stay in their chair, they can do. We give them a choice, a hot meal or a cold meal." Another staff member explained how they supported people to make choices when they could not communicate verbally. They told us, "You need to put it in front of them and observe where they are looking." There was information in care plans about people's communication needs. In one care plan it stated, "Understand mood by listening to intonation (tone of voice) and gestures. Give visual clues to assist in communication."

Staff understood their role in supporting people's privacy and dignity and most of the time we saw practices that promoted people's dignity. We observed two staff assisting a person to transfer. Their skirt was caught and the nurse immediately went over and quietly told the two staff members to pull the person's skirt down. Staff were able to give us examples of how they promoted privacy and dignity when providing personal care. These included using blankets to cover people when hoisting them and keeping the door to the shower closed. One staff member told us, "We cover them up, but we try and soothe them. Nobody comes into the room when we are washing the residents." People's rooms were personalised to their individual needs and contained personal photographs and possessions. People's relatives and visitors were able to visit when they wished so they could maintain relationships.

We noticed everyone was served their meals on red and green plastic plates and their drinks in plastic cups as opposed to crockery ones. This practice did not promote people's dignity or reflect person centred care. We could not determine from speaking with staff and the manager if there was any reason why people needed to use plastic plates. One staff member told us, "Everyone has plastic plates and beakers. Only one resident uses a glass because he doesn't want to use plastic." A visitor to the home commented they could not see why people could not use crockery plate and cups if they were "not too bad" referring to their dementia. The manager told us the red and green colours were considered to be "dementia friendly."

Good

Is the service responsive?

Our findings

People's needs were assessed by the service before they came to live at Sebright so staff could plan how their needs could be met although we found people did not have access to call bell leads. We were told nobody was able to use a call bell in the home but we identified at least two people who we saw reading a newspaper and magazine who potentially could use one. There were no assessments in place to show whether people could use them or not. We discussed this with the manager who told us one of these people used to have a call bell and she would look into this.

Family members told us they had been involved in decisions about how the care of their relative should be delivered. Family members had signed to confirm they had been involved in reviews of their family member's care. One relative told us, "Very happy with Mum's care." Another stated they had told staff about specific music and books the person liked. When they visited they had found their relative listening to the music they had chosen. They also saw picture books the manager had sourced for their relative. One person we spoke with told us, "I get a newspaper every day." This showed the manager and staff were responsive to meeting people's needs and preferences.

Staff were readily available in all areas of the home to respond to the needs of people quickly. For example, when people needed a tissue, staff were on hand to give them one. When people were coughing, staff promptly checked they were alright and gave them a drink of water.

We looked at the care plans for four people. We saw the care plans were detailed and promoted personalised care. They provided information which helped staff to anticipate and respond to the needs of people with limited verbal communication. They contained information about when people liked to eat and whether or not they chose to wear shoes and socks. Information in care plans showed where people had a preference for male or female care staff member. We saw both female and male care/nursing staff were on duty to help support these preferences.

Care staff told us if they noticed people required nursing support they would tell the nurse. One care staff member told us, "If there is a dressing that needs changing we go and tell the nurse." "If there are any changes, you have to tell the nurse so they can change the care plan for them." Care staff told us that any changes in people's needs were communicated at the handover between shifts. One care staff member told us, "It is all at the handover unless something happens during the day and everybody will be told." There was good information in care plans on how to respond and manage specific health care needs such as wounds. Records confirmed wounds were managed in accordance with the care plans in place. Two wound care plans we looked at showed the wound had either healed or was healing. This demonstrated the care practices being carried out promoted healing.

People had access to some social activities both in and outside of the home environment. There was an activity coordinator employed by the service who told us they planned yearly trips out and sourced local activity providers so that people had a variety of social activities and entertainment. There were photographs of a bonfire night party, Diwali and a trip to Gaydon demonstrating people's participation. We could not see that everybody benefited from social activities that were person centred. There were a number of people mainly asleep or sitting with their eyes closed in their chairs in the upper lounge. There was a mobile sensory light machine available in the corner of the lounge but the fibre optic light tubes and tracking balls in the bubble tube were not being used on an individual basis. It was mainly a visual display which meant it gave limited sensory stimulation for these people. When we looked at people's daily records of activities, they did not always reflect their past interests and hobbies they had told us about. Care records did not report on people's responses to the activities they participated in so staff knew which activities people particularly enjoyed and which ones they did not like to help when planning future activities and attendance. One person we spoke with told us they liked singing and walking and another stated they liked reading a newspaper. We saw these activities were provided.

Two relatives we spoke with told us they knew how to make a complaint if they needed to. They told us, "Yes I know how to make a complaint, I know the staff here, I have nothing but admiration for them." "I have had very little to complain about." A complaints procedure was available and it was recorded in people's care plans that information regarding the complaints procedure had been given to next-of-kin. The service had received two complaints in the previous 12 months and these had been suitably recorded

Good

Is the service responsive?

and responded to. There had been no further contact between the people who had made the complaints and the manager in relation to the outcomes to determine if they were happy or unhappy with the way their complaints had been managed.

Requires improvement

Is the service well-led?

Our findings

The registered manager has a legal responsibility to notify us of any incidents that affect people who use services. The manager had sent us notifications of accidents and incidents in the home but not all of the safeguarding incidents as required. This meant we did not receive information to help us assess whether further action needed to be taken. Despite this, we saw the registered manager had notified the local safeguarding authority of these incidents to enable any investigations to be appropriately completed.

People spoken with were limited in the information they could provide about the home and their involvement in decisions. People and relatives were not provided with regular opportunities to offer their opinion and be involved in decisions related to what happened in the home. Relatives meetings had periodically taken place but it was not always clear from the notes of the meetings what actions had been taken in response to issues raised.

There were audits of accidents and incidents carried out but the patterns and trends were not monitored to identify any potential changes in practice that may be required. Information within some audits was not accurate. This included the number of safeguarding incidents recorded each month and a health and safety checklist. The health and safety checklist was dated 15 September 2014 and stated carpets and flooring were in a satisfactory state of repair. We observed the flooring was worn and in a poor state of repair. This meant a misleading overview may be taken of risks and the resulting actions needed to manage these. The manager accepted the health and safety checklist was incorrect.

The manager told us the priority for improving the building was to complete the bedrooms first and the bathroom. Staff told us the one bathroom in the home had been out of use for over a year which meant people only had the option of a shower. We saw there was a maintenance plan to address repairs and the redecoration of the home but this did not state when tasks should be completed. We saw a maintenance person in the home at the time of our visit completing works to the bedrooms and the manager confirmed they were working their way around the home.

The manager told us a senior member of care staff worked in a supernumerary capacity for three shifts per week to help support her in tasks associated with running the home. Both care and nursing staff understood their responsibilities and spoke positively about the support they received from the registered manager. Staff told us, “She does [come out of the office] and she helps out with the caring. She talks to the residents, the resident’s families and gets involved with the activities.” “The manager is very approachable and listens.” “She knows what is happening in the home as she is always about.”

The manager was open with us about issues the service had dealt with over the last few months. She told us they had experienced challenges with employing the right calibre of staff to work at the home. There had also been challenges in making the home more “dementia friendly.” We saw changes to the environment in this respect were still in progress. We found the registered manager worked with other professionals such as the mental health team to ensure people received appropriate care and support.

Staff meetings were held periodically where they discussed the care of people, nursing issues, medication and new training courses for staff. This demonstrated the practices of the home were discussed as well as staff training to promote ongoing improvements in the care and services provided. Staff also participated in supervision where their performance and development was discussed with a senior member of staff. This included spot checks by management. The manager explained that staff were regularly observed so that any concerns regarding their actions, behaviours or practices could be addressed.

The manager’s office was off the main lounge which meant she had a good view of people and what was going on in the home. We observed the manager in the communal areas throughout the day speaking with staff, visitors and people to check all was well.

People and visitors we spoke with were complimentary of the service and care provided. We saw they had been asked to complete a quality survey during 2014. An outcome report showed there were some areas they felt needed improvement. There was no report made available to people and visitors so they could see how their comments had been actioned. The manager stated she had shared this information verbally with people and visitors.

We saw numerous thank you letters the service had received. They were very complimentary of the manager and staff. One relative commented, “Dear [manager] and all

Requires improvement

Is the service well-led?

the wonderful staff. Our father [person] was not part of the Sebright family for very long but on every unannounced visit we were amazed at the care and attention given to all residents."

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who use services who have their liberty restricted have not been appropriately assessed to determine whether the restriction is lawful under the Deprivation of Liberty Safeguards.