

Forest Care Limited

Cedar Lodge Nursing Home

Inspection report

St Catherine's Road
Frimley Green
Camberley
Surrey
GU16 9NP

Tel: 01252837019
Website: www.forestcare.co.uk

Date of inspection visit:
01 November 2016

Date of publication:
27 March 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection was carried out on 1 November 2016. Cedar Lodge Nursing Home provides accommodation, nursing care, respite and residential care for a maximum of 60 older people. At the time of our inspection 58 people were living at the service.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Recruitment practices were not always robust because appropriate checks had not been completed before staff started work.

Incidents and accidents were not always recorded or analysed to reduce the risk of them re-occurring.

Staff were not up to date with current guidance to support people to make decisions. Where people had restrictions placed on them there was no evidence that these were done in their best interests. MCA assessments were not being completed in relation to specific decisions.

Staff had not always received appropriate supervision and training. However other staff were having one to one support with their manager that promoted their development. People told us they felt supported and staff knew what they were doing.

There were not always sufficient numbers of care staff deployed at mealtimes to support people. However there were appropriate numbers of staff for other aspects of care.

There were not always appropriate arrangements in place to identify and support people who were nutritionally at risk. People were not complimentary about the food at the service. People were not always supported to have access to healthcare services. The provider was not always pro-active in referring people for assessment or treatment for specialist care.

The provider did not have appropriate systems in place to regularly assess and monitor the quality of the care provided. There was a continuing breach from the previous inspection around MCA assessments that had not been addressed. Records were not always legible, up to date or reflecting the most up to date care needs.

People had not always had access to activities that were important and relevant to them. However there were a range of activities available within the service and outside for some people that lived there.

People told us they were safe at the service. Staff had a good understanding about the signs of abuse and

were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

Assessments were undertaken to identify other risks to people to keep them safe.

Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. The service had a business contingency plan that identified how the service would function in the event of an emergency such as fire, adverse weather conditions, flooding or power cuts.

Medicines were managed, stored and disposed of safely. Any changes to people's medicines were prescribed by the person's GP and administered appropriately.

Staff treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration. People's privacy and dignity were respected and promoted when personal care was carried out.

People's needs were assessed when they entered the service and on a continuous basis to reflect changes in their needs.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Concerns and complaints were used as an opportunity to learn and improve the service.

Staff told us they would report any concerns to their manager. Staff felt that management were very supportive.

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 always safe.

Recruitment practices were not always safe because appropriate checks had not always been completed before staff commenced work.

There were enough staff deployed to meet people's needs at meal times however in other aspects of care there were appropriate numbers of staff.

People had risk assessments based on their individual care and support needs.

Medicines were administered, stored and disposed of safely.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Requires Improvement 

Is the service effective?

The service was not always effective.

Staff did not always understand or know how to apply legislation that supported people to consent to treatment. Where restrictions were in place there was not enough evidence to support that this was in the person best interest.

People were not always supported to have access to healthcare services and healthcare professionals were not always involved in the regular monitoring of people's health.

Staff did not always have the necessary skills and knowledge to meet people's assessed needs. Supervisions with staff were not up to date.

There were not always arrangements in place to identify and support people who were nutritionally at risk. People were not complimentary about the food at the service.

Requires Improvement 

Is the service caring?

Good 

The service was caring.

Staff treated people with compassion, kindness, dignity and respect.

People's privacy was respected and promoted.

Staff were happy, cheerful and caring towards people.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

The service was not always responsive.

People did not always have access to activities that were important and relevant to them. For other people there were a range of activities available within the home and community.

People's needs were assessed when they entered the home and on a continuous basis.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voices to be heard.

Requires Improvement ●

Is the service well-led?

The service was not well- led.

The provider did not have systems in place to effectively assess and monitor the quality of the service. The provider had not met their breach in regulation from the previous inspection.

Records were not well maintained and did not reflect the most up to date care that people received.

People told us the staff were friendly and supportive and management were approachable.

Staff were encouraged to contribute to the improvement of the service and staff would report any concerns to their manager.

Requires Improvement ●

Cedar Lodge 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 1 November 2016. The inspection team consisted of three inspectors, 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 service) and a nurse specialist.

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. We reviewed information on the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

During the visit we spoke with the registered manager, 17 people, two relatives and 11 members of staff. We looked at a sample of nine care records of people who used the service, medicine administration records and six recruitment and supervision records for staff. We looked at records that related to the management of the service. These included minutes of resident, relative and staff meetings and audits of the service.

The last inspection was on 22 July 2015 where one breach of regulation was identified. This related to the lack of assessments of people that may lack capacity to make decisions.

Is the service safe?

Our findings

Recruitment processes were not always robust. References had always been obtained in line with the service own recruitment policy. According to the service policy there needed to be two satisfactory references that should 'ideally come from current and or previous employers'. The registered manager told us that references should be sought from the managers from the member of staff's previous or present employer. Of the recruitment files we reviewed six of these did not have references from the previous employer. Instead the majority of the references were provided by care assistants that currently worked at Cedar Lodge Nursing Home. On one file although there were references from outside the organisation there was no detail around how the referees knew the member of staff or in what capacity they worked together. 'There were unexplained gaps in the work history without a written explanation to explain the gaps for in one file that we reviewed. Therefore the provider would have been unable to determine if the candidate was suitable to work with people. Previous conviction checks had been provided for all of the staff and there was proof of staff identity.

We recommend that the provider ensures that robust recruitment processes are place to include staff that are already working at the service.

Where the registered manager needed to sign the forms to state that all appropriate action had been taken this was not always being done. One person had been found on the floor twice on the same day however these incidents had not been recorded on the falls chart. There were incident reports of people falling over with injuries occurring but there was not always information recorded around how staff were to support the person to reduce the risk of this reoccurring. Where the registered manager needed to sign the forms to indicate they had reviewed the report, had oversight of the accidents occurring in the home and that appropriate action had been taken this was not always being done. The registered manager told us that they knew additional information should have been added. However the forms did not always contain information about the actions taken following an accident.

We recommend that the provider ensures all accidents and incidents are recorded appropriately with guidance on how to reduce the risks of these re-occurring.

People told us that they felt safe at the service and relatives felt their family members were safe. Comments included, "There is always someone (staff) around", "I feel very safe here, I have no worries", and "The staff pop in and see me last thing at night which makes me feel safe."

Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. They felt confident that they would be able to recognise abuse if it was occurring. One member of staff said that they would report any concerns of abuse to the manager. Another member of staff said, "I would report it to the manager or senior carer or ask other staff if I wanted to take it higher." There was a safeguarding adults policy and staff had received training in safeguarding people.

On the whole people felt there were enough staff to support them. One person told us, "There are always

people (staff) about to help me." During the inspection there were sufficient staff to meet people's needs. Staff provided care and support when people needed it. Morning personal care was completed within a reasonable time and people did not have to stay in bed longer than they wanted. When people used calls bells they were responded to quickly by a member of staff. The registered manager told us they reviewed the staffing levels regularly dependant on the needs of people. According to the rotas there were always the correct numbers of staff on duty each shift. One member of staff said, "There are enough staff, most mornings we have 12." This matched what the registered manager said that they needed.

However despite this there were times the deployment of staff needed better planning to meet people's needs appropriately. People who required support to eat did not receive this from staff as they were busy elsewhere. One person said, "They usually help but I know they are busy." We observed lunch being served in the dining room and on the first floor. It was disorganised and people were left waiting long periods of time for their meal. In the dining room everyone was seated at the tables however those that were on a soft diet were served first. People that were not on a soft diet waited at the table for over 45 minutes before they were given their meal. Whilst waiting for their meals people were leaving the table and coming back.

We recommend that the provider ensures that staff are deployed effectively so that people are provided with support at all times particularly at meal times.

Assessments were undertaken to identify risks to people. The environment was clean, the corridors wide and handrails had been fitted to aid with mobility. The flooring was in good state of repair and free from obstructions. People had walking aids and wheel chairs to assist them where necessary. Where bed rails were being used these were supported with a bed rails risk assessment. When clinical risks were identified, appropriate management plans were developed to reduce the likelihood of them occurring. Other risks were also assessed in relation to people's nutrition, mobility and skin integrity and risk management care plans were in place to minimise risks. The care plans identified the potential risks to people and gave instructions and guidelines to staff in order to manage those risks. We saw one example of a member of staff use an inappropriate technique to transfer a person from their wheelchair into a chair. They did not use a hoist to move the person despite this being needed according to their care plan. We fed this back to the registered manager. On the whole staff had knowledge of people's risks and what action they needed to take to protect people from harm. We saw staff caring for people in a way that was consistent with their care plans and kept them safe.

There were appropriate plans in place for use in the event of an emergency. In the event of a fire each person had a personal evacuation plan which was reviewed regularly by staff. Staff understood what they needed to do to help keep people safe. There was a business continuity plan in the event the building needed to be evacuated.

People's medicines were managed safely and people understood what medicines they received. There was a clear medicines policy and procedure in place and staff had had training in medicines management and been passed competent to dispense medicines. Staff demonstrated good knowledge of the medicines being dispensed. All prescriptions were appropriately signed and regularly reviewed by the G.P. Each person had their own Medicine Administration Record (MAR). In front of the MARs was a photograph to enable identification. We observed medicines being given and the nurse making the person comfortable. They checked the identity of the person and asked which medicine they would like to take first. The nurse checked that the person had taken the medicine before signing the recording sheet. There was a PRN (as and when required) protocol in place and this was reviewed regularly. Regular audits of medicines and the MAR sheets were undertaken.

Is the service effective?

Our findings

At our previous inspection in July 2015 we had identified a breach that related to the lack of Mental Capacity Act (MCA) assessments. There was a risk that decisions were being made by staff at the service that were not in people's best interests. However we found on this inspection that this had not been addressed and MCAs were still not being undertaken specific to decisions that needed to be made.

People's rights were not always protected because staff did not always act in accordance with the Mental Capacity Act 2005 (MCA). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. We saw assessments had been completed where people were unable to make decisions for themselves however the assessments were not always specific to the decision that needed to be made. There was a lack of understanding from staff that you should always assume people have capacity for each decision that needs to be made unless you have reason to doubt this. For example in relation to bed rails and straps on wheelchairs decisions had been made without exploring whether the person was able to understand what they needed and could consent to their use. There was lack of best interest decisions in relation to care. For example one person who lacked capacity had a bed rail in place. There was no record of a best interest meeting other than a note stating that the relative of the person agreed to the bed rail. Only relatives with legal authority such as power of attorney can make these decisions on someone's behalf. Each MCA we looked at was general about all the care and treatment people received at the service. Where it had been deemed that the person lacked capacity for general care staff had assumed the person lacked capacity for all decisions. One care plan stated 'GP makes decisions for her care and treatment in consultation with the family and staff in her best interest and in the least restrictive way.'

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 noted that applications for DoLS authorisations had been completed and submitted however these were in relation to people lacking capacity and not specifically where people's liberties may be restricted. For example in relation to bed rails, locked doors and lap belts on wheelchairs.

As care and treatment was not always provided with the appropriate consent this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were satisfied with the care that they received. One person told us that they had been to other services but Cedar Lodge was "The best I have ever been to." Another person said, "Staff massage my ankle and thigh each day which is what I need." A third person said, "I think staff know what they are doing." One person said they had been given good advice from staff on how best to care for the wound they had. They said the wound had improved since moving into the service.

Staff were not always receiving supervisions with their line manager. According to the training record that

the registered manager provided, staff had received training to meet people's needs. Care staff had not always received appropriate support that promoted their professional development. According to the records that the registered manager provided 17 staff had only had three supervisions, seven had only had two and three had only had one supervision since January 2016. Although supervisions were not always happening this had a low impact to people as generally staff were providing the most appropriate care. One member of staff told us that they met with their manager for one to one discussions and that they found them useful. We found that they were not happening as regularly as they needed to.

We did observe some good practice by staff on the day, particularly in relation to wound management, infection control, food hygiene and catheter care. One member of staff told us that they found the training they received "Effective." One health care professional told us that the staff at the service were willing to learn and that the nursing staff competencies were improving.

We recommend that staff are provided supervision based on the providers own expected standards.

We asked people about the food at the service. Comments included "It's not too bad", "Not good", "It can be chewy", "There is not a wide choice" and, "We can sit for a long time waiting for lunch."

People's nutritional needs were not always being met. For those that required support we saw them struggle to eat. One person did not eat any of their meal as they required staff to sit with them to encourage them. The person had lost a significant amount of weight although advice had been sought from the GP no other health care professionals had been contacted for this person in relation to their reluctance to eat. The person was not being weighed weekly despite this weight loss. Over a two month period the person had lost 7.75kgs. Their care plan stated 'Needs prompting and feeding at mealtime' and "Very reluctant to eat and at times forgetting how to eat, has lost weight." They were not receiving the support that was recorded as being required. Food and fluid charts were not always being completed where appropriate and where they were there were no target amounts for staff to establish if the correct amounts were being eaten and drunk. Another person had lost weight and there was no evidence that a health care professional had been contacted and the person was not on a food and fluid chart. The person only ate half of their meal on the day of the inspection. We raised our concerns with the manager who said that they would address this immediately with staff. They contacted us after the inspection and advised that they had now contacted appropriate health care professionals and were providing more support to people where needed.

Although people had been provided with a menu to choose from, this did not represent the choices available to them on the day. One member of staff told us that often what was provided was not what was on the menu. People were not offered a choice of drink but given an orange hydration drink. One member of staff told us that people could have water or juice but this was not offered to people on the day. One person said, "If you sit in the dining room you have to wait 20 minutes to be served and it's so noisy. If I sit in here (lounge) I can watch the television and I don't notice the time."

We recommend that the provider ensures people are always given support to have enough food and drink of their choice.

People did not always have access to health care professional support when they needed it. One person had been at the service for some months. They had been referred to the Speech and Language Therapist (SaLT) to assist with their speech. However it had been some months since this referral and the person had not had the necessary therapy they needed. This had resulted in additional anxiety for the person who struggled to communicate. No alternative therapy had been sought for this person. We raised this with the registered manager who told us that they would follow this up. The GP and community matron visited the service

regularly to provide support however we found that staff relied heavily upon the advice of the GP and were not always proactive in gaining advice and knowledge from health care professionals that had specific expertise.

Is the service caring?

Our findings

People told us that staff were caring. One person said, "They (staff) are very good, what would I do without them?" Another person said, "It's very nice here." One relative said, "The home is good." One health care professional said, "Staff are very kind, this service is lovely, friendly and so caring."

Staff showed concern for people's wellbeing in a caring and meaningful way. We saw staff stroking people's heads as they spoke with them, or bending down close whilst supporting a person to take liquid medicines. Staff asked people about their families and it was clear staff knew the families and what was going on in their lives. One staff member was providing care and singing and people commented positively on that. One person asked staff if someone could make up their bed as they had changed their sheets during the morning. We checked with the person and they told us this had been done for them. Staff acknowledged people as they walked past them. We heard one person refusing their medicines. The nurse explained what the medicine was for and gently persuaded the person to take it. The nurse sat down next to the person while they spoke to them.

Staff spoke with people in a respectful manner and treated people with dignity. Staff knocked on people's doors before entering and checking people were okay, or supporting them to access the lift to go downstairs. Where people requested help with going to the toilet, staff responded to this quickly. Staff referred to some people as 'Mr' or 'Mrs' and staff asked people if they could move them in their chair to another part of the service. For example to the dining room for lunch. Men were clean shaven and staff ensured that people were supported to be dressed in an appropriate way to maintain their dignity.

People were able to make choices about when to get up in the morning, what to wear and where they would like to sit. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. One person said, "I have a lovely room. It's cosy and like home. I've brought my budgie in with me." Another person told us, "Staff support me to do things for myself, but support me with the things I can't do, like washing and putting my sandals on." One health care professional said, "The residents are so involved, it's what makes this place a home."

Relatives and friends were encouraged to visit and maintain relationships with people. One person said, "My family can come and go as they please". People confirmed that they were able to practice their religious beliefs. We saw that religious services were held in the service and these were open to those who wished to attend.

Is the service responsive?

Our findings

We saw that pre-admission assessments were completed that provided information about people's needs and support. This was to ensure that people's needs could be met at the service. There were care records which outlined people's individual care and support needs. For example, personal hygiene, medicine, health, safety and environmental issues and mobility. Staff always ensured that relatives were kept informed of any changes to their family member. One relative told us that staff contacted them if there was any concern about their family member.

Staff told us that they completed a handover session after each shift which outlined changes to people's needs. Information shared at handover related to a change in people's medicine, healthcare appointments and messages to staff. We observed staff doing a handover on the day. Daily records were also completed to record each person's daily activities, personal care given, what went well and what did not and any action taken. The staff had up to date information relating to people's care needs.

We asked people about activities on offer at the service. One person said, "There are lots of activities" whilst another said, "We have a nice atmosphere during activities and a nice chat."

We saw activities being offered to people at the service however due to the size of the activities room these were only offered to a small group. One person wanted to join in an activity but was not able to as there was not enough space in the room where the game was being played. Instead they were offered an alternative activity. The person told us "Never mind, I can play with them next time." We saw a member of staff offer a particular activity to two people that were sitting in the lounge but the activity was not offered to others. Those that took part in the activity were enjoying it but there were people sitting in the lounge for long periods of time without something being offered. It was unclear whether this was through choice or because not enough activity was on offer for people who may wish to participate. One member of staff told us, "The activities are good but there could be more for people downstairs." On other days there were other activities on offer to people that included manicures, pampering sessions, hand massage, puzzles, entertainers and quizzes. There were also seasonal events arranged by the registered manager where families were welcomed.

We recommend that activities are person centred and that each person has the opportunity for meaningful engagement.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People knew how to complain. One person said, "If I had to complain I know it would be dealt with." There had been four complaints since our last inspection. These had been investigated thoroughly and people and their relatives were satisfied with the response. For example one person complained that staff were too noisy at night time. The person was visited by the registered manager and an alternative room was offered to the person and staff were reminded to be aware of the noise levels.

Is the service well-led?

Our findings

We were not informed of all of the shortfalls at the service despite us identifying these on the day. The registered manager initially told us that they had met the previous breach from the inspection in July 2015 in relation to MCA assessments. We found that this was not the case. The registered manager told us that they did not have any other concerns with the care delivery or running of the service. It was not until we pointed out the areas of concerns that the registered manager told us that they were already aware of this. For example in relation to the care plans not being up to date and the records not being in good order.

There were aspects of the quality assurance process that were not effective and had not identified gaps that we found on the day. The care plans we reviewed were not always up to date and did not reflect the most up to date care that staff were providing. One care plan stated that the person 'needs supervision from staff when mobilising'. However we saw the person moving around the service unsupported. Staff told us the care plan needed to be updated to reflect that the person no longer needed a member of staff with them. Another person's care plan stated that the person's food and fluid needed to be recorded. However staff told us this was no longer necessary. A third person's care plan stated that the person required a sensor mat in their room and their frame with them at all times. When we saw the person they were sitting in the lounge without their frame (as it was no longer needed) and there was no sensor mat in their room. Staff told us that their mobility had increased and that this was no longer needed.

The accidents and incidents that were recorded were not analysed identity trends. The registered manager told us that they discussed with staff any incidents with people each week. When we asked the registered manager if they were able to tell us how many incidents or accidents one person had had, they told us they would need to review all the weekly reports. The registered manager acknowledged that collating the information would be a better way of looking at trends around incidents and used as a way of reducing the risk of re-occurrence.

There were aspects of the record keeping at the service that required improvement. Care plans were difficult to read and poorly maintained. Food and fluid charts were not always completed consistently or at the time. Where daily checks were being undertaken to ensure that pressure mattresses were working, there was no information on the check sheet around what the person's weight was. Staff were unable to check that the pressure of the mattress was correct against the person's weight. In one room the mattress had been put at the incorrect setting as the person had lost weight. Guidance around the type of thickener the person needed was in their room however it was displaying the wrong information. Staff told us that the person had moved to stage two thickener however the guidance stated stage one. Another person had diabetes however the nursing staff we spoke to were not aware of the correct diagnosis of diabetes as the care plan had the incorrect information. We raised all these concerns with staff on the day who addressed this straight away. A monthly documentation, records and record keeping audit was undertaken by the provider. This had not identified any of the concerns in relation to care plans and records.

Where feedback had been sought from staff this had not been used as an opportunity to improve the service. In September 2016 staff were asked to complete a survey to gain their views. Comments raised

during the survey included 'there is sometimes no team work', '(the staff) need to help each other more', 'helping new staff makes us work slower' and one suggestion that 'day and night staff work together better'. When we asked the registered manager if any actions had been taken as a result of the survey they were unable to provide any evidence of this. Staff commented to us that the communication between care staff and nurses needed to improve. This was also raised in the staff survey. One member of staff told us, "Nurses don't spend enough time with the residents. They are writing the care plans and they don't know the people they write down things that are not correct. We wish they would come and talk to us." This was reflected in the care plans that we looked at on the day. We did not see evidence that this had been addressed. The registered manager told us that they had not recognised this as a concern.

Where feedback had been sought from people this had not always been used to improve the quality of care. In surveys completed in 2016 people mentioned that they would like more specific activities however this information had not been passed to the activities coordinator. One person said that they wanted more classical music to be played in the lounge however the activities coordinator told us that they were not aware of this.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete, accurate and legible. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not effectively monitor what was happening in the service. 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 not informed the CQC of significant events. We saw that one person had a head injury and required stitches. However this had not been notified to the CQC. After the inspection we asked the registered manager to send us details of the safeguarding incidents, which they did.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Registration) Regulations 2009.

People confirmed that they attended the residents and relatives meetings. We saw minutes of the meeting where people discussed meals, new staff, food and activities. Where people had raised staffing concerns we saw from the action plans that this was addressed. There were positive comments from the surveys that were completed by people and relatives. These included, 'Everything that I could wish for', 'Absolutely perfect', 'Really good', 'Very clean', 'Staff very friendly', 'Can't find any fault.'

People told us that they were happy with the management of the service. One person said, "The manager is very good." They told us that they felt listened to if they had any concerns. Staff thought the registered manager was good and staff felt valued. One member of staff said, "The manager tries her best, at times she makes you feel the best member of staff ever."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Diagnostic and screening procedures	The provider had not ensured that notifications had been submitted where appropriate.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Diagnostic and screening procedures	The provider had not ensured that care and treatment was provided with the appropriate consent.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider had not ensured that appropriate systems were in place to assess, monitor and improve the quality of the service, and the records were not always complete, accurate and legible.
Treatment of disease, disorder or injury	