Regal Care Trading Ltd

Ashcroft Nursing 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 18 and 19 June 2018 and was unannounced.

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

Ashcroft Nursing Home accommodates up to 88 people in one adapted building, some people may be living with dementia. At the time of the inspection 48 people were living on the ground and first floors of the service.

There was a registered manager in post, however, they were not in charge of the service on a day to day basis. Until February 2018, there had been another registered manager in post, who worked at the service daily. At the time of the inspection, there was an acting manager working at the service who was responsible for the day to day oversight of the service. They had recently made an application to us to become the new registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in March 2016 and the service was rated Good. This inspection was undertaken in response to information from the local safeguarding authority about how people with behaviours that challenge had been supported. At this inspection, four breaches of regulation were identified.

Potential risks to people's health and welfare such as epilepsy had not been consistently assessed and staff did not have detailed guidance to mitigate the risk and support people needed when they were unwell. Checks had been completed on the environment and equipment that people used to make sure it was safe. However, no action had been taken when the temperature of the water in some people's bedrooms were above the recommended limit to reduce the risk of scalding. Following the inspection, the acting manager sent us records to show that action had been taken to reduce the water temperatures.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. Some people had gates in their doorways and were independently mobile but were restricted from going into and leaving their rooms. There were no records about how this decision had been made and if this was the least restrictive way to support these people.

Each person had a care plan, that covered all aspects of their lives including physical and social needs. However, the care plans did not always contain detail about people's choices and preferences. Some people had been identified as being at the end of their lives, their wishes and the support they needed was not

recorded in their care plan. Staff had received training in end of life care and could support people to be comfortable.

Staff and the provider completed audits on the quality of the service. When shortfalls were identified, an action plan was put in place. However, these plans were not checked to confirm the action had been completed, plans were signed as completed before the all the action had been taken. The action taken in response to the audits and shortfalls found was not embedded as further shortfalls were found at this inspection.

Before the inspection, concerns had been raised that incidents involving people who displayed behaviours that challenge, had not been managed effectively. The acting manager had put systems in place to manage future incidents and people's behaviour. Accidents had been recorded and analysed to identify trends and patterns. Action had been taken to reduce the risk of accidents happening and records showed that the action had been effective.

Staff and the acting manager understood their responsibilities to keep people safe and report any concerns they may have. Staff were confident that the acting manager would take appropriate action. People received their medicines safely and when they needed them.

There were sufficient staff, who had been recruited safely, to meet people's needs. Agency staff were used to cover staff shortages, agency staff told us they did not work by themselves and had received an induction. Staff received training appropriate to their role and additional training had been introduced when needed to meet people's needs. New staff received an induction and staff received supervision and felt supported by the acting manager.

People were assessed before moving to the service to make sure that staff could meet their needs. People's needs were assessed in line with current guidelines. Staff monitored people's health and any changes were reported to healthcare professionals and staff followed the guidance given.

People were supported to eat and drink enough to maintain a balanced diet. People were given a choice of meals and staff supported them to make choices throughout the day. People were encouraged to take part in exercise and lead a healthy lifestyle.

People told us staff were caring and respected their privacy and dignity. We observed this throughout the inspection, staff treated people with respect and encouraged them to be as independent as possible. People were supported to express their views and where possible involved in planning their care. People were given information in a format they could understand.

People and relatives told us they knew how to complain. When complaints had been received they were investigated in line with the provider's policy and action taken to learn from the complaint.

The acting manager had a vision for the service and staff supported this, to make the service person centred. People were encouraged to take part in activities they enjoyed and meetings to express their views and shape the service. Staff and people completed quality surveys, these had been analysed and improvements had been made. The acting manager attended provider meetings to keep up to date with changes.

The service was clean and free from odour. The building was adapted to meet people's needs including secure outside space. Signage around the building was designed to support people living with dementia. Checks had been completed on the building and equipment to ensure it was safe for people to use.

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. CQC check that appropriate action had been taken. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall and on the provider website.

At this inspection four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Potential risks had not been consistently assessed and staff did not have detailed guidance to mitigate risks. Action had not always been taken to rectify shortfalls.

Staff understood their responsibilities to report any concerns to keep people safe.

There were sufficient staff to meet people's needs, who had been recruited safely.

People received their medicines safely and when they needed them.

The service was clean and odour free.

Accidents had been analysed and action taken to reduce the risk of them happening again.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always act within the principles of the Mental Capacity Act 2005. Some decisions had not been recorded to show the decision was the least restrictive possible.

People's needs were assessed in line with current guidance.

Staff had training appropriate to their needs and used it in their practice. Staff received supervision to discuss their development.

People were supported to eat and drink enough to maintain a balanced diet.

Staff worked with healthcare professionals and followed their guidance. People were supported to lead healthier lives.

The building had been adapted to meet people's needs, signage

was appropriate for people living with dementia.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect.

People were encouraged to express their views about their care and given information in a way they could understand.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always accurate and detailed to give staff guidance to provide person centred care.

Some people were receiving end of life care but this had not been recorded in their care plan.

People took part in activities they enjoyed.

People told us they knew how to complain, any complaints received were investigated in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

Checks and audits had identified shortfalls, however, action had not always been taken. When action was taken this had not been embedded into practice.

There was a person centred culture within the service.

People and staff were asked their opinions on the service and action was taken when suggestions were made.

The acting manager worked with agencies to improve care and support.

The acting manager attended provider meetings to keep up to date with changes.

Ashcroft 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 checked 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 was prompted by information shared by the local safeguarding authority. There had been concerns about how people with behaviour that challenged were being supported and people were being kept safe.

This inspection took place on 18 and 19 June 2018 and was unannounced.

The inspection was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information about the service the provider had sent us in the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us by law.

We looked a nine people's care plans, associated risk assessments and medicines records. We looked at three staff recruitment files, training, supervision and maintenance records. We spoke with the registered manager, acting manager, six care staff, two agency care staff, two activities co-ordinators and the maintenance person. We spoke with 15 people who use the service and four relatives.

Some people were not able to talk with us and explain their experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experiences of people who unable to talk with us.

We spoke with two social care professionals after the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person told us, "I feel safe and happy here." Another person told us, "Yes, it is a nice place here and we are safe now and well looked after."

Potential risks to people's health and welfare had not been consistently assessed and there was no detailed guidance for staff to mitigate risks. Some people needed support with their mobility and required specialist equipment to help them move around the building. The information in the moving and handling risk assessments did not give staff information about where to position sling straps to keep people safe. There was limited guidance for staff to support people who needed support with health needs when mobilising such as limb weakness and which type of sling to use.

Some people were living with epilepsy, there were risk assessments in place. However, the risk assessments used the term 'petite mal' this is out of date terminology of epileptic seizures. Staff were provided with a link to NHS guidance but as this term is not used in the guidance, there was a risk that staff would not understand the signs of a seizure and what action to take, or know what the term 'petite mal' meant.

There were some potential risks that had not been identified. Some people had been admitted to hospital with health conditions but the risk of these conditions occurring again had not been assessed. For example, one person had required a catheter (a tube that drains urine from the bladder) as they had not been able to pass urine when they were admitted to hospital. This had not been recognised by staff at the service. When the catheter had been removed, there was a risk that this may happen again, but there was no guidance for staff to recognise the symptoms of not being able to pass urine and what action to take. The acting manager included the information in the care plan during the inspection.

Checks had been completed on the water temperatures in the building, to monitor that they were within the recommended temperatures, to reduce the risk of scalding. However, records showed that since January 2018 water temperatures in some bedrooms were consistently over the recommended 43c.The acting manager had not known about the high water temperatures and action had not been taken. People could access the taps in bedrooms and there was a risk of people being injured.

Following the inspection, the acting manager sent the current water temperatures, action had been taken and all temperatures were within the recommended temperatures.

The registered persons had failed to consistently assess and doing all that is reasonably practicable to mitigate risks to the health and safety of people receiving care or treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks and audits had been completed on the environment and equipment people used to make sure it was safe. There was a fire risk assessment in place and work was being completed to rectify the shortfalls identified. Checks were completed on fire equipment. Each person had a personal emergency evacuation plan in place, giving information about how a person could be evacuated safely in the event of an

emergency.

Before the inspection, concerns had been raised that incidents involving people who displayed behaviours that challenge, had not been supported effectively. The acting manager had reviewed the systems in place for reporting safeguarding incidents and how they were managed. The review had identified shortfalls in how people had been supported. The acting manager had analysed previous incidents and had identified actions that needed to be taken to prevent them from happening again. For example, alarms had been put around one person's door, so that staff were alerted when they left their room. Staff were then able to offer the person support when they needed it. There had been no further incidents reported.

Accidents had been recorded and analysed to identify trends and patterns. The acting manager had identified in January 2018 that most of the falls happened on the ground floor at night. The staffing on the ground floor was increased and there was a reduction in falls to none in May 2018.

People received their medicines safely and when they needed them. There were systems in place to order, record and administer medicines. Staff were trained to administer medicines and their competencies were checked. We observed a medicine round and people were supported to take their medicines in a kind and caring way.

The temperature of the rooms and fridges where medicines were stored had been monitored to ensure that the temperatures were within the recommended limits to ensure that medicines remain effective. Some medicines were in liquid form, it had been recorded when the bottle had been opened to ensure medicines were discarded before they stopped being effective. Handwritten directives had been signed by two staff to confirm the directive was correct. Some people were prescribed medicines on an 'as and when' basis such as pain relief. There was detailed guidance in place for staff to follow about when to give medicines and how often.

Some people were prescribed creams to keep their skin healthy, staff recorded when they applied creams. Staff recorded when they administered medicines and records were accurate.

There were sufficient staff on duty to meet people's needs. One relative told us, "There is always plenty of staff around and they know what they are doing." Shortfalls in staffing levels were covered by agency staff. The acting manager told us that they used the same agency staff to provide continuity of care. Agency staff told us they worked with permanent staff to support people that need support from two staff. Duty rotas confirmed that there had been a constant number of staff on duty. During the inspection, staff responded quickly to people's requests and could spend time with people.

Staff were recruited safely. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with vulnerable people. There was a full employment history, references and identification. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Nurses Personal Identification Number was checked to ensure nurses registered to practice.

The service was clean and odour free. Staff followed the provider's policies to protect people from infection. Staff wore protective clothing such as gloves and aprons when required. There were sufficient domestic staff to maintain the cleanliness of the service.

Requires Improvement

Is the service effective?

Our findings

People told us that staff supported them to make choices. One person told us, "I choose when I want to get up and where I would like to have breakfast."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA.

During the inspection, we observed that some people had gates across the doorway to their rooms. The acting manager told us that families had requested that these were put in place to stop other people going into the rooms. However, when care plans were reviewed for people with gates in place, there was no reference to how the decision had been made to put the gate in place.

We reviewed two care plans where people had gates in place. Both people had been assessed as not having capacity to make complex decisions and were independently mobile. The use of the gate in their doorway meant that they would not be able to come and go from their room as they wanted. The provider had not recorded how the decision had been made and what alternatives had been considered to ensure the use of the gate was the least restrictive. There was no guidance for staff about how to reduce the restriction for people. The provider had a risk assessment for the use of the gates but it did not include guidance about how to make and record the decision. The acting manager told us that the decision had not been recorded for anyone with a gate in place.

The registered persons had failed to act in accordance with the requirements of the Mental Capacity Act 2005, where a person lacks mental capacity to make an informed decision. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's mental capacity had been assessed and DoLS applications had been made when required. Some DoLS had been authorised but had now expired, appropriate action had been taken and another DoLS was applied for before the previous one had expired.

Staff encouraged and supported people to make day to day decisions. We observed staff asking people what they wanted to eat and drink or spend their time. Staff described how they supported people to make choices, by showing them two items of clothing or meals.

Before moving into the service, people were assessed to make sure that staff could meet their needs. The assessment covered all areas of the person's life including cultural, spiritual and sexuality. This assessment

formed the basis of the person's care plan. People's needs were assessed in line with current guidelines from National Institute of Clinical Excellence, using recognised tools. Each person had an assessment for nutrition, falls and skin integrity and this was used to plan people's care.

People's health was monitored by staff and any changes were reported to healthcare professionals such as the GP or district nurse. When people lost weight, they were referred to the dietician and their guidance was followed by staff to help people maintain a healthy weight. Some people had difficulty with swallowing, they had been referred to the speech and language therapist, staff followed the guidance and people were able to eat and drink safely.

People were supported to lead healthier lives, people were supported to participate in exercise as much as possible, such as walking around the grounds or playing football. People were supported to have access to health professionals such as dentist, chiropodist and optician as required.

People told us they were offered a choice of meals. One person told us, "We get a choice of meals from a menu each day." People with specialist diets were catered for such as vegetarian and gluten free. When people did not want what was on the menu, other meals were prepared, we observed staff offering one person several different choices until they decided on a ham sandwich.

People were supported to eat their meals when required. People could take their time and staff encouraged people to be as independent as possible with their meals. People could eat their meals where they wanted, some people chose to eat in their rooms. Some people chose to eat their meals in the dining rooms, lunch time was a social occasion and people chatted between themselves.

Staff received training appropriate to their role. Staff completed online training and face to face training for some subjects such as moving and handling. Staff received training in health conditions such as dementia. Staff were observed putting their training into practice, we observed staff diffuse an argument between two people that could have led to an altercation. The acting manager had put in place positive behaviour support training, as part of the system for supporting people with behaviours that may challenge.

New and agency staff received an induction. This included working with experienced staff to learn people's choices and preferences. Permanent staff had their competencies assessed before they could work alone. Agency staff confirmed that they always worked with a member of permanent staff.

Staff told us they felt supported by the acting manager and felt they could approach them with any concerns they may have. The acting manager had put in place a timetable for all staff to receive regular supervision. This had begun, all the staff had received a supervision in the previous two months. Nurses received clinical supervision from the acting manager.

Ashcroft is a purpose built building. People lived on the ground and first floor, accessed by a passenger lift. There are accessible gardens for people to use and various communal rooms. The signage around the building was appropriate for people who may be living with dementia.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One person told us, "I am so spoilt and well looked after by lovely staff." A relative told us, "So caring I cannot quite believe my luck bringing my (loved one) here."

People were encouraged to maintain their independence. We observed staff supporting people to walk with their walking aids, staff spoke to guide and encourage them. Staff supported and guided people to think about how they would complete an activity. For example, how to complete a puzzle, staff asked people questions so that they knew where the pieces went, and helped when needed.

Staff knew people well and responded to their moods. Staff supported one person when their friend did not want to spend time with them and they became upset. They asked the person to help them in the garden so they were kept active. The person smiled and was observed laughing when helping in the garden.

We observed and staff told us how they knocked on people's doors and waited to be asked in. Relatives told us that staff explained what they were going to do. One relative told us, "I have noticed how good they are by always explaining things first, they never just barge in and start."

Some people living at the service could not speak English there were some staff who could speak their language, and these staff sat and chatted with people each day. The people were supported to express their views by staff using a translation app. Staff told us this had been effective in finding out what people wanted.

People were given information in a way they could understand. When people were living with dementia, they were provided information in pictorial and easy read formats, to enable them to give their opinions and be part of their care planning.

People were able, some with support, to share their views about their care and treatment with staff and others. When people required support to do this they were supported by their families, solicitor, their care manager or an advocate. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

People were encouraged to personalise their rooms. People had ornaments and pictures of their family in their rooms. People were supported to maintain relationships with their family and friends. Relatives told us that could visit at any time and were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed and were encouraged to be involved in planning their care. One person told us, "I have a care plan and yes I have seen it, but I do not want to be involved."

Each person had a care plan that included all elements of their lives, including social and spiritual. The care plans were stored electronically and completed by staff. The care plans were inconsistent in the detail included to make them person centred. We reviewed two communication care plans, these contained the same action for staff to follow. Both care plans contained the same mistake, they referred to each person as female where they were male.

Some care plans recognised that people needed emotional support, however, there was little or no guidance for staff to support each individual. Care plans included statements such as 'Staff able to reassure if they look worried or sad' and '(Name) to have all support needed to maintain emotional stability.' The care plans did not describe how to support each person and how to reassure them.

The guidance for the support that people needed to maintain their personal hygiene was limited. For example, one care plan stated the person liked a strip wash and shave daily and needed the assistance of one staff. There was no guidance about how staff were to assist the person or what type of shave they liked.

Care plans contained a section for people's end of life wishes to be recorded. People's wishes had not been consistently asked or recorded. Some people were at the end of their life, this was recorded in their care plan when decided by the GP. However, there was no additional guidance for staff, one person's end of life plan stated 'Ensure (name) wishes are met.' There was no information about what these wishes were. The end of life care plans for people who had been identified as being at the end of their lives were generic and did not contain personalised information.

The acting manager had introduced a 'zoning' system to identify people who needed additional support or their needs had changed. Meetings took place on a Monday and identified when people were at risk or their physical or mental health had changed. An action plan was agreed for staff to support people, but this was not consistently recorded in the care plans. The outcome of the meeting and zoning was displayed in the office that staff had access to.

The registered persons had failed to design care and treatment with a view to achieving people's preferences and ensuring needs are met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training in palliative care and nurses could support people with the administration of medicines to keep them comfortable. Staff made sure that medicines were available when people needed it. Staff liaised with the GP and district nurses to ensure people's needs were met.

People could enjoy a range of activities, there were activities co-ordinators available each day to support people. People were supported to maintain their hobbies and interests and encouraged to take part in new activities. During the inspection, observed people enjoying outside entertainment, people were singing and dancing. On the second day of the inspection, people took part in a game of skittles, people were shouting and cheering, enjoying the competition.

People received one to one time when they remained in their room. The co-ordinators spent time with people helping them with quizzes or reading the paper. Relatives told us that they were surprised at how sociable their loved ones had become. One relative told us, "We have been surprised by how much they have livened up and they are more sociable than they have ever been."

The provider had a complaints policy that was available in the main reception. Complaints received this year had been investigated according to the policy. The outcomes had been recorded and any action taken, for example, a person had been losing their bell. It was agreed that a walkie talkie was brought so the person was able to talk to staff directly.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they thought the service was well led. One person told us, "yes, the staff do ask what we think and ask how we feel things could improve." One relative, "We are more than happy by the way it is led here, I often chat with the manager and staff, they are most welcoming and do listen."

There was a manager registered with the Care Quality Commission (CQC), but they were not in day to day charge of the service. There had been another registered manager in post, who was based at the service, they had left their post in March 2018. There was now an acting manager in post who was a nurse and had been working at the service since September 2017. They had just started the process of registering with CQC and had experience of managing services for the provider.

Regular checks and audits had been completed by the provider and staff. Shortfalls had been identified and action plans put in place, however, the action plans had not always been completed or signed as being checked by the acting manager. Some action plans had been signed as being completed but this was not always accurate. For example, a health and safety audit had identified that carbon monoxide detectors were needed, the action plan was signed as complete when the detectors had been ordered. It had not recorded that the detectors had arrived and been fitted. We confirmed they had been fitted during the inspection.

Care plan audits by the provider had identified shortfalls in the care plans they reviewed, however, the changes needed to rectify the shortfalls had not been transferred to the remaining care plans. The provider did not record that they had checked that the previous action plan had been completed. The audits had not been effective in improving the quality of the care plans.

Checks on the environment had been completed but action had not been taken to adjust water temperatures to reduce the risk of scalding.

People's records were not accurate and up to date, they did not contain detailed guidance for staff to follow to mitigate risks. Care plans did not consistently contain guidance for staff to provide person centred care in line with people's choices and preferences.

The registered persons had failed to maintain accurate and complete records. The registered persons had failed to effectively assess and improve the quality and safety of the service and mitigate risks. This is a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager recognised the shortfalls within the service and had been working to make improvements. They had worked with the local commissioning groups and local safeguarding authority to improve the management and support for people living with behaviour that may challenge. The improvements could be seen in the reduction of incidents in the previous two months.

The acting manager understood the need for the service to constantly improve and their role within that process. They attended meetings with the provider's other registered managers to keep up to date with any

changes. The acting manager told us that they were aware of local forums and would be attending them in the future.

The acting manager had a vision that the service would be person centred and people would be supported in the way they preferred to enjoy their lives. Staff supported the acting manager in this goal. The activities co-ordinator promoted a person-centred approach to activities and for people to be involved in the service.

People could attend 'Dignity Meetings' held by the activities co-ordinator, every three months. People were could request one to one meetings to discuss any personal issues that they may have. People and relatives told us that changes had been made following the meetings. People had raised concerns over the call bells in the lounge and people not being able to reach them, there were now hand held bells in place.

People and staff completed quality assurance surveys in 2018. The resident survey had made comments about the choice at breakfast, requesting 'real' porridge be included in the choice. The menu in the dining rooms and people confirmed that 'real' porridge was now available. Staff raised concerns about the amount of repeat sickness and that a more action should be taken to combat this. The acting manager had followed the provider's sickness policy and completed back to work interviews, the sickness level within the service had reduced.

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. CQC check that appropriate action had been taken. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall and on their website.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons had failed to design care and treatment with a view to achieving people's preferences and ensuring needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons had failed to act in accordance with the requirements of the Mental Capacity Act 2005, where a person lacks mental capacity to make an informed decision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to consistently assess and doing all that is reasonably practicable to mitigate risks to the health and safety of people receiving care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to maintain accurate and complete records. The registered persons had failed to effectively assess and improve the quality and safety of the service

and mitigate risks.