Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Wentworth Croft Residential and 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection was carried out on 30 October 2014 and 12 November 2014. The last inspection took place on 14 May 2014, during which we found a continued breach in regulation 9, care and welfare of people who use services. We asked the provider to make the improvements required and they wrote to us and told us that these improvements would be completed by 31 August 2014. During this inspection we found that the provider had made the required improvements.

Wentworth Croft Residential and Nursing Home is a registered care home that provides accommodation for up to 156 mainly older people who require nursing and/or personal care. The home offers accommodation over one floor within four separate units called Woolsack, Hayward, Harvester and Yeoman. Each unit has single occupancy bedrooms with ensuite facilities and there are

Summary of findings

internal and external communal areas, including lounges, dining areas and gardens for people and their visitors to use. There were 123 people using the service at the time of our visit.

At the time of our inspection a registered manager was in place. 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.

During this inspection we found that there was not enough staff to meet people's care and support needs in a timely manner and to keep them safe. Two out of the four units had two staff absent on each, and the registered manager told us that they had been unable to cover their absence. Staff rotas we looked at showed that there were also previous occasions when the number of staff that had worked was lower than the required number of staff.

Quality monitoring systems were in place, but these were not always effective in identifying solutions to staff sickness levels and absenteeism.

People we spoke with and our observations showed us that staff were caring. We saw staff interact with people in a kind and respectful manner. However, these interactions were infrequent as staff were busy concentrating on their tasks for the day as they were short staffed.

People had been assessed under the Mental Capacity Act 2005 (MCA) and where the person was found to lack capacity to make their own decisions, an application to the supervisory body (local authority) had not always been carried out under the Deprivation of Liberty Safeguards (DoLS).

Staff undertook a range of training to make sure that they were able to support and care for people's individual needs in an effective way. Staff understood their roles and responsibilities and were supported by the management to maintain their skills by way of regular supervision, competency checks and training updates.

Checks were carried out on all potential new staff to ensure that they were deemed safe to work with people who lived in the home.

Medicines were stored safely and at the correct temperature. We found that the provider followed safe medicines administration procedures and that this was in line with their policies.

People had a choice of meals which were designed to be nutritional and well balanced. People at risk of malnutrition were assessed by external health care professionals and we saw that this input and advice had been followed by staff.

There was a system in place to receive and manage complaints. However, it was not always clear on looking at the complaints records, whether a complaint had been resolved to the person's satisfaction.

People, their relatives and staff had been asked to provide their feedback on the quality of the service provided so that the service could see what was going well and what required improvement.

The registered manager is required to inform the CQC of important events that occur at the service. During this inspection we found that this had not always happened.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People's individual care and support needs were not always met in a timely manner as there was not a sufficient number of staff provided.

Staff were recruited safely and trained to meet the needs of people who lived in the home.

Staff were trained and knowledgeable on how to recognise the signs of abuse. They knew how to respond and report any concerns that they may have, so as to reduce the risk of abuse occurring.

Is the service effective?

Requires Improvement

The service was not effective.

People had been assessed under the MCA. However, where the person was found to lack capacity to make their own decisions, an application to the DoLS supervisory body had not always been carried out.

The majority of people and relatives of people told us that they were happy with the care their family member received. They told us that they were involved in the planning of their / their family member's health, care and support needs. However, some relatives and people told us of their concerns around low staffing levels.

People were supported to maintain a nutritional diet. People's nutritional health and well-being was monitored by staff and any concerns acted on.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives told us that staff were caring, but they raised concerns about low staffing levels. We found that due to the lack of staff on duty, staff had insufficient time to spend positively interacting with people who used the service.

We saw that staff encouraged people to make their own choices where possible about things that were important to them.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

Activities happened within the home, but we found that due to a shortage of staff people were not always able to be supported by staff to take part or maintain their individual interests.

Summary of findings

There was a system in place to receive and manage complaints. However, it was not always clear whether complaints were resolved to the person's satisfaction.

Is the service well-led?

Requires Improvement

The service was not well-led.

Although there were systems in place to monitor the quality of the service provided, these systems had identified but had not yet resolved the concerns around insufficient staffing levels, staff sickness levels and absenteeism.

The registered manager had not notified the Care Quality Commission of events within the home that they are required to inform us about as part of their role as the 'registered person'.

People who lived in the home, their relatives and staff were asked for their opinions on the quality of the service provided.

Wentworth Croft Residential and 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 took place on 30 October and 12 November 2014 and was unannounced.

This inspection was completed by three inspectors, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. Before the inspection, we asked the provider to complete and return a 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 any improvements they plan to make. The provider completed and returned the PIR form to us and we used this information as part of our inspection planning.

We looked at other information that we held about the service including information received and notifications. Notifications are information on important events that happen in the home that the provider is required to notify us about by law. We also looked at the local authority reports from recent visits and we spoke with social workers.

On the day of our visit, we observed how the staff interacted with people who lived in the home. 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 18 people who used the service and 10 relatives of people who used the service. We also spoke with the registered manager, two clinical service managers, head of care, two unit managers, two deputy unit managers, two nurses, 15 care staff, and seven non care staff. We sought feedback about the service from a continuing health care nurse assessor and a tissue viability nurse who were visiting the home on the day of our inspection.

As part of this inspection we looked at 10 people's care records and five staff records. We looked at other documentation such as quality monitoring information, complaints and compliments, staffing rotas for each unit, people's dependency risk assessments, controlled drug records and the location's business contingency plan.

Requires Improvement

Is the service safe?

Our findings

Our observations throughout our visit showed that there were not enough staff to provide a safe level of care and support to people in a timely way. This was confirmed by the majority of people and their relatives we spoke with. A person told of an occasion when they had waited for staff assistance and the delay had ended with them feeling undignified and as such distressed. They said that, "It can take some time to answer the call bell and has been as long as two hours." One relative said, "Sometimes I feel there could be more staff here," another relative told us that they were, "Worried that sometimes (there's) not enough staff."

The majority of staff spoken with also spoke of their concerns about low staffing levels. One staff member told us that, "We are so understaffed, staff stay over their time to cover, [staff name] should have gone at 2pm but has stayed until 4pm."

We carried out a SOFI during lunchtime in the residential/ dementia unit and observations in the other units at this time. We saw little or no communication between staff and people due to the lack of staff on duty. On the residential/ dementia unit we saw a person getting increasingly agitated and upset about where they could sit for lunch. Staff around at the time were focused on serving up lunch to people and had insufficient time to spend interacting with this person to lessen their increasing agitation. After 20 minutes we saw that the person left the dining area in a continued state of anxiety. This meant that people did not benefit from a service where there was enough staff to provide support that met their individual and complex needs.

Our observations throughout the day showed occasions when there were no staff present in the communal areas. This was because they were caring for people within their own rooms. In the residential unit we saw that one person needed some personal assistance from staff. No staff were to be found in the communal area at this time. Another person who used the service had to try and find a member of staff for them, to provide the personal support that they needed. This showed us that there were not enough staff to provide support to people in a timely manner.

We spoke with staff about staffing levels during our visit. A staff member told us that on days when the staffing levels were low, "Everything is done, but personal care maybe a bit later." This was confirmed by a person on the nursing unit who said that at 10.45am they were, "Waiting for [staff] to get me up." Later on during our visit, a staff member on the nursing unit informed us that at 3pm, eight people had still not received their morning personal care and support from staff due to the shortfall in the number of staff on duty.

The registered manager told us they had looked at the current levels of staff sickness and absenteeism. They then showed us the risk assessments undertaken to assess people's dependency levels which determined the safe number of staff support each person required. This information was then used to plan the minimum number of staff each unit should have during each shift, to remain safe. However, despite this analysis, on the day of our inspection they had been unable to find alternative staff cover from their pool of bank and agency staff to meet their minimum safe staffing levels.

Due to our concerns around low staffing levels we then looked at staff rotas for the month of October 2014. We found other examples of where there was not a full quota of staff on duty. The nursing/dementia unit on 21 October 2014 showed that from 8am to 8pm there were only five staff working instead of the required six staff members.

This demonstrated to us that there were not enough staff to respond to people's needs in a timely manner. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had individual risk assessments undertaken in relation to their identified health care and support needs. We saw that specific risk assessments were in place for, but not limited to; people at risk of falls, moving and handling and the use of bedrails. These risk assessments gave guidance to staff to help support people to live as independent a life as possible, and reduce the risk of people receiving inappropriate or unsafe care and support. However, in the residential/ dementia unit we saw that two people had taken themselves off to bed. We found that neither had their alarm mat in place in line with their risk assessment to ensure their safety. One alarm mat was plugged in, but was folded up on a shelf behind the person's bed. The other alarm mat had been pushed underneath the bed. We spoke with a member of staff at

Requires Improvement

Is the service safe?

the time who confirmed to us that the alarm mats, used as a way for people to alert staff, should have been in place by the side of the bed. This posed a risk to people's safety, as not all safety equipment was in its correct place.

People and their relatives we spoke with had some positive comments about the service they or their family member received. One person on the residential unit told us that, "The friendliness of the staff and feeling secure," was what the staff on the unit did well.

Staff we spoke with demonstrated to us their knowledge on how to identify and report any suspicions of abuse. Whistle-blowing information on how to report abuse was on display for staff to refer to if needed. Staff were clear about their responsibilities to report abuse and this showed us that staff knew the procedures in place to reduce the risk of abuse.

Staff we spoke with talked us through the pre-employment checks carried out on them prior to them starting work at the home. Records we looked at confirmed this and this demonstrated to us that there was a system in place to make sure that staff were only employed if they were deemed suitable and safe to work with people who lived in the home.

People we spoke with had no concerns around their medication support from staff. However, two people told us that when they had asked staff what their medication was for, staff were unable to tell them. Staff confirmed to us that staff who carried out prescribed medication prompting and administration had been trained to undertake this task. We found that medications were stored safely and at the correct temperature. People had been risk assessed to see if they needed staff assistance to either prompt or administer their prescribed medication. One person told us that, "Staff watch that you take your medicine." We saw that staff completed the medication administration records (MARs) after the medication had been administered as per their protocol. Our observations showed that medication rounds were spaced so that people were given their prescribed medication at safe intervals.

We found that people had a personal emergency evacuation plan in place and that there was an overall business contingency plan in case of an emergency. This document gave details of nearby buildings that people could be evacuated to if needed and a list of emergency contacts and their details. This demonstrated to us that there was a plan in place to assist people to be evacuated safely in the event of a fire or other emergency.

Requires Improvement

Is the service effective?

Our findings

During our visit, one person we spoke with in the residential/ dementia unit kept asking to be shown the front door as they wanted to leave. They were unable to leave the unit by themselves as there was a key coded security system in place. This security system in place within all units, restricted people's freedom of movement to and from the unit, unless the person was accompanied by a staff member. We spoke with the registered manager about the Mental Capacity Act 2005 (MCA) and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people living at the home who were assessed as being unable to make their own decisions. We saw evidence of communication with the supervisory body (local authority) to understand and work in line with the current guidelines regarding the appropriate and lawful deprivation of people's liberty. However, we found that only three DoLs applications to the supervisory body had been made by the registered manager in recent months in line with current guidelines even though people's freedom of movement was restricted by the security system in place.

Staff we spoke with told us that they supported people to regularly access external health care professionals when needed. A unit manager talked through the improvement of a person with a skin sore and how working with an external health care professional and the care given had been effective in reducing this sore. This they told us, made them feel, "Proud." A person we spoke with also confirmed that, "I see a doctor when I need to and staff take me to hospital when I need to go." A relative we spoke with told us that the staff, "Keep me informed," of her family members health care needs. During our inspection we spoke with two visiting health care professionals. The tissue viability nurse told us that staff followed their advice and that this had been effective in managing people at risk of poor skin integrity.

We found that staff were knowledgeable about people's individual care and support needs. Staff told us about the range of training they had completed to make sure that they had the skills to provide the individual care and support people needed. Staff also told us about the development plan they had in place to progress their skills and knowledge. Competency checks were carried out on staff for areas of training such as the administration of prescribed medication. This showed us that the registered manager had an effective system in place to monitor staff training and competencies.

The provider information return detailed how staff were to develop their training skills and knowledge to continue to impact positively on people who used the service. Examples of this included training on how to reduce or prevent hospital admissions from the home. Records we looked at showed us that staff had already been allocated places to attend this training.

Staff told us that they were supported by receiving regular supervisions. We also saw that new staff were supported with a comprehensive induction process. Staff's competence was then assessed to ensure they were suitable to provide safe and effective care, support and treatment.

We carried out a SOFI during lunchtime on the residential/ nursing unit and undertook observations throughout the other units. The chef told us and we saw that there was a choice of two main meals that had been created from set recipes to give people a balanced diet.

People were helped by staff to make a choice on which meal they would prefer by being shown the food plated up. If people preferred, they could choose an alternative. One person we spoke with said that, "Staff will bring a sandwich or biscuits if I request them." Another person told us that," They feed you really well." We saw that where needed, people were supported with adapted cutlery or crockery to enable them to eat independently. We also observed that staff when supporting people with their meals, carried this out at the preferred pace of the person they were assisting.

External health care advice had been sought by staff for people at risk of weight loss or at risk of choking when swallowing. We saw that people were provided with soft texture diets, thickened drinks and fortified food and that their weight was monitored by staff. However, we found that the daily food diary completed by staff to record the amount of food people had eaten, did not document people's exact food intake. This meant that these records did not identify in enough detail, a person's daily food intake to reduce risks relating to poor nutrition due to a person's lack of appetite.

Requires Improvement

Is the service caring?

Our findings

Throughout our visit, we saw that the residential unit and nursing unit had two staff absent on each during the day, without cover. We could see that staff were busy concentrating on undertaking the tasks needed. However, due to staff shortages, we saw little time for all staff to positively interact with people who lived in the home. Some staff had adopted a task orientated approach to care which did not always facilitate meaningful interactions. A staff member explained to us the effect low staffing had on people who used the service. They said that, "We don't have the time to chat with people, they need more than just care, we really don't have time to spend sitting with people."

People were assisted by staff to be as independent as possible. We saw staff encourage people to do as much for themselves as they were able to. To assist with their independence, some people had equipment in place to help with this, such as care call bells. We saw that staff were aware of which people needed additional support to maintain their independence. We found that the majority of times staff made sure that this equipment was provided. However, we did observe some care call bells that were not in reach of people and as such put those at risk of not being able to alert staff quickly when needed.

We found that some people were using the communal areas of the home. We saw on the residential / nursing unit that five people were being encouraged to work on a jigsaw puzzle with the activities co-ordinator. We noted that the staff member engaged with and responded to those people who had chosen to take part in this activity in a caring, kind and patient manner.

We also saw a person who had been very anxious and upset previously in the day, sitting calmly with the activities coordinator knitting. We noted that this one-to-one engagement with a staff member and positive interaction had resulted in the person responding in a much calmer and less anxious manner.

People and their relatives provided us with mixed feedback about the quality of the service provided. One person told us that, "The staff are very good." Whilst a relative told us, "They keep me informed." Another relative we spoke with said that, "They do their absolute best to look after [family member], there are some carers who have been here a long time and they know [family members] ways." However, due to staff shortages we were told by the registered manager that agency staff were used by the service to cover staff absenteeism. Some relatives and people who we spoke with expressed a concern over the use of agency staff as this was not their preference. A relative said that, "Agency staff are not as good as permanent staff, not as confident in their ability." This concern was also shared by a person who told us that they have different staff all of the time, "Some come from an agency and they don't know my needs so I have to go through it with them."

We found that people's privacy was respected by staff. Throughout the day we saw that staff knocked on people's doors and waited for permission to go in before entering their room. Relatives we spoke with told us that their family member received, "Pretty reasonable personal care, fine 95% of the time. Staff treat [family member] well and explain what they are going to do."

We saw that people were dressed appropriately for the temperature within the home and in a manner that maintained their dignity. A relative told us that they, "Feel [family member] is well looked after, always clean and dressed appropriately."

We saw that advocacy information for people and their relatives was available in areas of the home for people to refer to if needed. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Some people had legal representation to help them with making choices around financial decisions or care and welfare decisions when they had been assessed as being unable to make these decisions for themselves.

Requires Improvement

Is the service responsive?

Our findings

Prior to living at the home, people's needs were assessed, planned and evaluated to agree their plan of care and support. We saw that people and where appropriate their next of kin, were involved in the review of and agreed their care and support plans.

Care records showed that people's health, care and support needs were documented and monitored by staff. One person spoken with said, "The staff look after me well. They know what they are doing. I have no complaints at all." A visiting continuing health care nurse assessor gave us some examples of how staff had responded to their suggestions to help improve people's care.

We saw that care records contained specific documents to be maintained by staff to detail care tasks such as personal care having been undertaken. Where people were deemed to be at risk of poor skin integrity, weight loss and dehydration there were also records in place to monitor and respond to these risks. These records monitored people at risk so staff could respond promptly to any concerns. The majority of records were completed by staff as required, however we found gaps in people's personal care documentation which meant that they were an incomplete record. We spoke with the clinical services manager at the time and they assured us that personal care had been given, but had not been recorded as such. This meant that there was a risk of in-complete personalised care and support records for people who used the service.

People on one unit told us that although bingo and quizzes happened, staff did not have the time to assist people with their hobbies and social interests during the absence of an activities co-ordinator. We also saw in the residential / dementia unit that several people at 11.30am had taken themselves back off to bed to sleep fully dressed. One person we spoke with on the nursing unit told us that they, "Get bored and sometimes fall asleep." In the residential unit we saw that there was a musical entertainer performing in the communal lounge. This social event was not well attended by people who lived in the home. We asked staff where people were and why there was such a low response to this entertainment. The staff member told us that they had not been aware that this entertainment was happening within their unit. They also said that they had not had the time, due to staff shortages, to assist people from their bedrooms to attend this musical event. In response to low staff levels, people had missed the opportunity to be entertained and to have a positive social engagement with other people who used the service.

In other units we observed activities such as pumpkin carving and decorations for Halloween, as well as singing and ball games taking place. We also saw other people in the communal lounges sat dozing whilst music played in the background throughout the day, with little or no social interactions.

We spoke with the registered manager about links with the local community. They told us that these linked were maintained by inviting local residents to attend Wentworth Croft Residential and Nursing Home's fetes and events. On the day of our inspection, we saw a banner had been placed at the homes entrance which advertised to local people that there was a Christmas bazaar soon, which they were welcome to attend. We also saw in the care records we looked at that people were supported where appropriate to go out shopping with their relative. A person we spoke with told us how they had been supported by their family member to go out on a trip to visit a local market town.

We saw that people were supported to maintain contact with their relatives and friends, who were seen visiting them. We spoke with staff who confirmed to us that there was no set visiting hours for families and friends to adhere to. One relative told us of a time during a visit, when they had been encouraged by staff to also take part in a group social event.

We spoke to the chef during our visit about whether the service would be able to respond if a person had any special cultural dietary requirements. The chef told us that if a person moved into the home with these requirements they would be able to react promptly and cater for the individual's diet. This showed us that the service was able to consider and respond to people's individual cultural needs.

We saw that people's compliments and complaints were used to inform the services on-going quality monitoring system. People who lived in the home and their relatives told us that the majority of the time if a concern was raised with staff it was resolved satisfactorily. One relative we spoke with told us that, "There are new procedures in place and in the last year there have been no problems at all."

Requires Improvement

Is the service responsive?

However, some people we spoke with told us that they did not know the name of the manager of their unit or the home to address their concerns to, should they wish to do so.

We asked staff what action they would take if a person raised a complaint to them. They confirmed to us that they would raise these concerns with the unit manager. We looked at recent compliments and complaints received by the service and found that the complaints records did not always document clearly whether the concern had been resolved to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems in place to identify trends and areas of risk within the service did not always resolve the areas found to be requiring improvement. We found that each unit carried out their own quality monitoring on areas of risk such as, medication administration records, compliments and complaints received, safeguarding concerns and incidents. However, although these systems were in place to assess the quality of the service, these checks had not identified the risk to people's safety where alarm mats and call bells were not in the correct place. Our findings were that the improvements required and subsequent actions taken by management did not always resolve the area of risk satisfactorily.

Quality monitoring had identified low staffing levels due to staff sickness and absenteeism prior to our visit. However, on the day of our inspection, we saw that the minimum number of staff required per shift was not the number working. Two out of the four units were short of two staff each and the service had not been able to cover this shortfall. Due to a shortage of staff, staff were seen to be task orientated, there were delays to people's personal care support being delivered. Staff were seen to be busy and as such we saw that there were infrequent social interactions between staff and people. One staff member told us that they, "Don't have the staff to support the role of manager." This meant that the quality monitoring system and required actions had not made sure that there was always enough staff to meet people's care and support needs in a safe and timely manner.

This was a breach of Regulation 10 (1) (a) (b) (2) (b) (iii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with the registered manager during our inspection and they confirmed to us that they were not aware that as the 'registered person' they were required to notify the Care Quality Commission (CQC) of certain incidents, events and changes that affect a service, or the people who used it. We found that only 11 out of 45 safeguarding incidents that had been investigated by the local authority safeguarding team, had been notified to the CQC by the registered manager. We also became aware during our inspection that the CQC had not received notifications to inform us that three people who used the service had a Deprivation of Liberty Safeguard application authorised by the supervisory body (local authority) to lawfully restrict their movements.

These matters were a breach of Regulation 18 (2) (c) (d) and (5) (b) Health and Social Care Act 2008 (regulated Activities) Regulations 2010.

People and their relatives were given the opportunity to feedback on the quality of the service provided. We were told that there were in-house post boxes, where people and their visitors could feedback their thoughts anonymously on the service, but that these were not often used. The limited information was however used to improve the quality of service provided where possible. Surveys for people, their relatives and staff were also sent out to gather opinions on the service. The reports we saw collated the feedback received, and showed positive comments about the service and some areas of improvement required.

We saw that the registered manager had set up two relatives meetings as an opportunity to discuss the quality of service provided in the home and any future plans at the home. The clinical services manager told us that the last two meetings were cancelled as no relatives had attended. They went on to tell us that they felt that this was because communication had improved between management and families of people living at the home.

Staff told us that staff meetings occurred and this was confirmed by the staff meeting records we looked at. We spoke to staff about whether they felt supported by the registered manager of the home. One staff member said in reference to minimum staffing levels not always being reached that the, "Manager (is) always trying to support you but this is not always being achieved." Two other staff members told how one evening they had felt so overwhelmed at work that they had gone home and cried. This showed us that there were not always the resources in place to support and develop the staff team.

Staff showed us that they understood their roles and responsibilities to people who lived in the home. They knew the lines of management to follow if they had any concerns to raise. They demonstrated to us their knowledge and understanding of the whistle-blowing procedure.

Requires Improvement

Is the service well-led?

The provider information return had detailed the plan of how the registered manager wanted to turn the home into more of a 'village' to improve the service for people who lived there. During our inspection the registered manager talked us through their plans to have a sensory room and a cinema room set aside, for people to use and enjoy. Work had already started on this, with a beauty salon room nearly completed on the residential/dementia unit.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The health, safety and welfare of people who lived at the home were not protected, because there was insufficient staff to meet people's health, care and support needs safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: The on-going quality monitoring system had not resolved all identified areas of improvement required and protected people who lived in the home against the risk of insufficient staffing levels and safety equipment not being in the correct place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered manager as the 'registered person' had not notified the Care Quality Commission of certain incidents, events and changes that affect a service, or the people who used it.