Aspire Life Care Limited

Westdene House

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**

Summary of findings

Overall summary

An unannounced comprehensive inspection took place on 18 June and 22 June 2018.

Westdene House is registered to provide accommodation for up to 14 older people that may require personal care. Some people at the home were living with dementia. The home provides short term/respite stays. On the inspection there were 12 people residing at the home.

Westdene House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the 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. On the day of our inspection the registered manager was away so we spoke to the person in charge who oversaw the day to day running of the home.

At our last inspection on 15 March 2016, the service was rated as 'Good' overall with the key questions of 'Safe' being rated as 'Requires improvement', as concerns were identified relating to the safe management of medicines. At this inspection medicines were being stored, managed and administered safely but other concerns around people's safety were identified.

Staff did not always know people well enough to support them safely or to evacuate people safely in the event of an emergency. Evacuation plans were not up to date for people. People's risks were assessed and documented but records were not always up to date and did not accurately reflect the needs of the person. Staff were given training and were trained in moving people safely but an instance of staff practice was observed to be unsafe. Records were not always accurate, for example care plans did not provide staff with clear or up to date information. If someone's needs had changed plans did not always reflect this. Staff carried out a range of audits but these did not have clear actions to improve the service.

There were policies and procedures to safeguard people from abuse but staff did not always understand safeguarding processes. Records showed that staff did not arrange immediate or timely access to healthcare following incidents such as a fall where injuries may have been sustained. Staff told us that if a person fell staff did not immediately seek healthcare help to assess what care they needed. People's health care needs were not always monitored however staff did liaise with health care and mental health services such as referrals for people.

People were not always protected from the risks of infection control and prevention and some areas of the home were not well maintained. People's rooms and areas of the home were not always clean and there were unpleasant odours in certain areas throughout the inspection. We have recommended that there is a

review of the frequency and effectiveness of the carpet shampooing regime at the home.

Records showed that people's capacity to consent to care and treatment was not always assessed in line with best practice guidance and procedures to make best interest decisions were not in place. People were not encouraged to express themselves or to be involved in their own care. Staff had basic awareness of the principles as set out in the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards (DoLS) but records and staff's understanding showed principles were not put into practice.

People were not always treated in a caring or respectful way by staff but some kind interactions were observed. People told us they were not supported to participate in activities of their choice or pursue hobbies and people did not receive support that was responsive to their individual needs and interests. Records showed that a weekly structured activity programme was in place and people were asked for feedback in resident's meetings on activities. People's privacy was not always supported by adaptations to the premises or by staff.

We observed a lunchtime meal, people were not always supported to eat and drink well. Drinks and snacks were not observed to be freely available throughout the day for people apart from water observed in some rooms. People were supported to have a balanced and nutritious diet and were supported to choose their meals from options provided to them. People were provided with a balanced diet that was suitable to their individual needs.

At this inspection we found five breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version 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.

Risks to people were not always well managed.

The home was not well maintained.

Staff were trained to recognise the signs of potential abuse but did not fully understand what action to take.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained but training had not always been effective to ensure safe practice.

People's capacity to consent to care and treatment was not assessed in line with best practice guidance.

Westdene House has not always adapted the premises to meet the needs of people.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff with personal care. People were not always treated in a caring way by all staff throughout all our observations.

People's privacy was not supported by the premises or by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not provide staff with clear or up to date information.

People had access to structured activities but were not supported to participate in activities of their choice or pursue

hobbies.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider and registered manager carried out a range of audits but these did not have clear actions to improve the service.

People and relatives were asked for their views about the service. Staff were asked for suggestions and feedback.

Westdene House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 June and 22 June and was unannounced. On the inspection there were 12 people residing at the home.

Before the inspection we checked the information that we held about the home and the provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to send to us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send 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 used all this information to decide which areas to focus on during our inspection.

Two inspectors and an expert-by-experience undertook the first day of inspection and two inspectors undertook the second visit. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service including dementia and older people's services.

During the visit we spoke to the deputy manager, a senior carer, a carer and the cook. We spoke with seven people. We observed how staff interacted with people who used the service and supported them in the communal areas of the home and in their rooms. We also observed a lunchtime meal. We looked at three people's care records and four staff files. We looked at records such as risk assessments, incident records, medicine records and staff training records. We also looked at a range of records relating to the management of the service such as complaints records and audits.

Following the inspection we received feedback from four health and social care external professionals who supported Westdene House, who gave permission for us to quote them. We reviewed policies, procedures and records after the inspection.

Requires Improvement

Is the service safe?

Our findings

At the last inspection, we identified that medicines were not safely managed. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made requirements for this to be addressed and during the last inspection the registered manager took prompt action to resolve the issues found. This included Medicine administration records now being completed for people receiving respite care. We received an updated copy of their process for admitting people for respite care shortly after the last inspection. The registered manager had introduced information for PRN medicines to provide guidance to staff and the registered manager had provided additional support to staff with medicines. At this inspection, medicines were administered and stored safely and this Regulation was now being met.

A person told us "I feel safe. There's always someone around and they make sure I get my medicine for my diabetes." Another person told us, "I always get given my medicines no problem." All care staff had medication training and their competency was assessed annually. New staff shadow a more experienced member of staff and are supervised until assessed successfully to be competent to administer medicines. Medicines that require special administration processes were managed safely and in line with good practice guidance. Staff understood requirements of people that were living with diabetes or who required blood thinning medicines at specific times. Medicines were disposed of safely. Staff worked well with their pharmacy who reviewed medicines annually and carried out audits for the home.

People were not supported by staff to move around the home safely. Staff told us that a person would not leave their room because of their mobility issues. Staff did not find ways to enable and support the person to leave their room by assessing the risk to the person and identifying ways that any risks could be managed. We observed one instance of unsafe moving and handling practice, staff were observed lifting a person using an under-arm technique to transfer a person from a wheelchair to a seat. This was immediately fed back to the staff member in charge.

We observed that one person's mobility equipment was not used safely. A person who used a wheelchair was observed to be uncomfortable sitting in the wheelchair, their wheelchair did not have foot plates so their feet were left suspended without support. Foot plates were attached after we asked where the footplates are.

People were not always protected from the risks of infection. Bins were left open in bathrooms with equipment such as soiled catheter leg bags and plastic gloves which had been worn by staff who completed personal care for people. Staff served food and supported people to eat without wearing appropriate protective equipment such as aprons.

We have recommended that there is a review of the frequency and effectiveness of the carpet shampooing regime at the home.

People were not always protected from hazardous chemicals. The cupboard that hazardous cleaning

products were stored in was left open in a corridor frequently used by people and hazardous cleaning products were on the first-floor bathroom floor, this placed people at risk of accidental consumption.

Systems were not in place so that people can be safely and quickly evacuated in the event of a fire or other emergency. Processes had not been put in place to guide staff to keep people safe in an emergency such as a fire. People had a personal emergency evacuation plan (PEEP) but information was not correct, for example the PEEP did not reflect the support a person may require to leave the building during a fire. A rescue mat was available on the first floor to assist someone who may require support to evacuate the building down the stairs but the rescue mat was not mentioned in people's PEEPs which meant there was a risk that this equipment may not be used appropriately or used for those who required it. In one person's PEEP it did not say how to exit from different parts of the building, this was important because the person used a wheelchair and needed two members of staff to support them to stand. The front door was locked, only staff had access to keys and the door would not open in the event of a fire without being unlocked. Fire extinguishers were serviced and were available around the home. Staff were trained in fire safety. The home had an evacuation procedure and business continuity plan. Staff told us there is a fire alarm test on a weekly basis. Following this inspection, the CQC were notified that a fire safety visit had taken place by a competent person and areas of shortfall that needed rectifying had been identified. These shortfalls were confirmed to be resolved in October 2018.

People were not always given timely access to healthcare if they had a fall or accident to assess what care they needed. Incident forms showed and staff told us that if a person fell staff did not immediately seek healthcare help to assess what care they needed. Staff did not fully understand how to respond to an incident to keep people safe and systems were not in place to support people to get the help they may need after an incident such as a fall.

The failure to assess and mitigate risks to people's health and safety was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems, processes and practices did not always protect people from the risks of abuse and avoidable harm. Staff told us that they would report any safety concerns to the manager but staff did not know how to report safeguarding concerns in the absence of the manager, there was no evidence to suggest that safeguarding concerns had not been reported and therefore this was fedback to the person in charge to address. People told us they felt safe, for example, a person told us, "I feel safe here. I get on well with all the girls. I think it's the attitude of the staff that makes me feel safe."

We observed there were enough staff to meet people's needs and staff rotas showed that staffing levels were appropriate to meet people's needs during the day and at night. The person in charge during our visits told us that the registered manager monitored and reviewed staffing levels. As well as personal care, care staff undertook housekeeping duties such as cleaning, laundry and ironing. At night there were two staff, one member of staff was waking and another not but were available if needed.

Checks were completed to ensure safety such as checking the safety of water systems to ensure correct and safe water temperatures, gas safety and electrical systems.

Staff recruitment practices were safe. Staff were only able to commence employment after the registered manager had received two satisfactory references. Staff held a current Disclosure and Barring Service (DBS) check. Recruitment checks helped to ensure that suitable staff supported people safely.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood the basic principles of the Mental Capacity Act 2005 (MCA) but did not have a good understanding of how to assess people's capacity to make particular decisions. Records showed that decisions that needed to be taken in people's best interests had been taken by a member of staff and did not always include people, relatives or external professionals in the decision-making process. Following the inspection, we saw a record of a best interest decisions meeting involving health and social care professionals, relatives and people.

Some of the people had been assessed as lacking capacity and then were not involved in any specific decisions about their care. Some care plans showed a lack of understanding about the impact of power of attorney and of advanced care decisions. For example, a person's relative had power of attorney for finances but had been involved in making advanced care decisions for their relative even though they did not have power of attorney for health and welfare. An advanced care plan was seen stating that an advanced care decision had been made to not resuscitate but there was not an appropriately signed Do Not Attempt Resuscitation (DNR) document on file.

In some care plans people had given consent to receive care, to CCTV recording in communal areas and to have their medicines stored for them. Some care plans showed inconsistencies. For example, one person's care plan stated that the person lacked capacity to consent to their care needs being met but no capacity assessment had been done to document this judgement noted by staff. A person was observed wearing a lap belt with the wheelchair, staff could not explain, and records did not show, how consent had been sought or how the person had been involved in the decision to wear a lap belt.

Restrictive practices were not always appropriate for people. Stairs had a gate but the gate was not locked or fixed, staff could not explain why a stair gate was in place so it was not possible to assess whether the gate was a restrictive measure to restrict people moving around freely at the home.

The failure to always seek consent for care and treatment was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were not adapted to meet every person's needs. The provider did not review how to suitably meet people's diverse physical needs. For example, one person who used a wheelchair was observed to find it difficult to get through narrow corridors outside of their room.

The premises were not well maintained and clean throughout to provide people with a pleasant environment to live in. The gardens to the rear and front were not well maintained. Throughout our visits there was an unpleasant odour in some parts of the home and particularly in some people's bedrooms. Carpet cleaning rotas were shown to us following the inspection but these did not show that the carpets were cleaned as regularly as staff had told us and due to the unpleasant odours, it was not clear how effective the carpet cleaning was. Cleaning tasks were allocated on a weekly and monthly basis to staff but the months records showed that staff had not done these and there was no action taken to address this. Following the inspection, we were shown maintenance records that showed issues were identified in people's rooms.

People told us that they thought staff were well trained and knew what help they needed. One person said, "I think they [staff] are well trained. They're very good at helping me with washing and dressing and things like that." Staff told us they had access to training, such as qualifications like the Care Certificate, a set of nationally recognised standards that staff are expected to complete to work with people in care settings, and National Vocational Qualifications (NVQs). Some training was delivered by the provider and registered manager. For example, one staff member had covered 14 mandatory courses such as basic first aid, dementia awareness and fire safety. Staff told us they have an induction week when they first start their role. Staff understood pressure relief to prevent pressure sores, personal care requirements and the principles of the Mental Capacity Act (2005). Training topics were also covered in staff meetings, for example a recent staff meeting had discussed the new General Data Protection Regulations (2018).

External health care professionals, for example a dementia and admission avoidance matron, told us that staff followed instructions and care advice given by the professionals. Other external professionals told us that the provider engaged well with them and accepted support and guidance offered. Care plans showed that people were being referred to external professionals and are accessing healthcare and support for conditions. one person told us, "I'm sure they would call the doctor if I needed one." Another person told us, "I haven't seen the doctor lately but I expect they'd arrange it if I was ill." Staff told us that one person had been referred to the bladder and bowel service and people living with dementia were being supported by the living well with dementia team.

People were supported to have a balanced diet. People were supported to choose from a menu with two options. A person told us that, "The food is alright. We get a cup of tea in the morning and in the afternoon." We observed that people enjoyed the meals. A person told us, "I only go down for lunch. I think the food is very good." Food was homemade by the cook and the cook baked fresh cakes for the evening meal daily. During our visit we observed the cook speaking to people to choose what they would like for lunch. People were seen to enjoy the friendly interaction with the cook. Risks to people with complex nutritional needs were addressed such as for a person with diabetes or receiving end of life care. The menu is planned to consider people's likes and dislikes and nutritional needs. The cook told us about people's allergies and dietary needs and people were given a pureed diet when they required this, we observed this followed at lunchtime and saw dietary need documented in records.

Staff told us and records showed that staff had regular supervision with either the registered manager or deputy manager. Staff told us they felt they can raise concerns to a manager at any time. Records showed that staff had an annual appraisal with the registered manager.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a dignified and caring way.

People did not always receive appropriate support to maintain their dignity. People were observed wearing food soiled clothing and being left with food around their mouth. Some people had behaviour that challenged and staff did not always show confidence in how to manage this behaviour and talked about experiences with people displaying behaviour that challenges insensitively. A person had a care plan for managing their distress, the plan did not tell staff how to minimise or respond to the persons distress. Following the inspection, the registered manager provided a care plan for distress that gave clearer guidance to staff.

Staff told us that people had behaviour that challenges with continence care and declining to shower. A shower rota showed that people had declined to wash and the shower rota offered people a shower once a week. Care plans did not explain what to do if a person refused to have a shower and staff could not tell us what they would do if a person refuses to have a shower or if there were strategies for trying different things. The person in charge told us that if a person declines to have a shower the staff will work with external teams to support the person but records did not show this. In one person's care plan it said that the person enjoys having a shower but it did not record how often to offer a shower to the person. Another person's care plan said that the person likes to have a shower once a week, the persons daily chart showed that they had a shower three weeks ago and had been supported to wash in their sink once since then. Following the inspection, the registered manager told us they intend to change the way staff record when people have a shower.

People's privacy and dignity were not always promoted or respected. The shower used by people was next to the conservatory lounge with frosted glass, people can sit opposite the bathroom in the lounge.

Staff did not always interact with people when supporting a person to eat or when giving care and spoke to people in a disrespectful and insensitive way. Staff were seen putting plates down in front of people without introducing the food or using the opportunity for a kind interaction with the person.

We observed a caring interaction between a senior carer and a person who was upset. Some interactions were observed to be driven by personal care tasks rather than being warm and kind, for example observations showed opportunities to have meaningful interactions were missed. Some people were observed to stay in their room. Some people told us it was their choice to remain in their rooms while others were not supported to leave their room, two people were being cared for in bed due to ill health. People in communal areas were not engaged in conversation or activities.

People told us that staff are often "too busy to chat". One person told us "most of the girls are nice but they don't have time to sit around chatting, they're always too busy." Another said "Some of them are very kind and will do anything for you, but others are very abrupt. They just want to do what they have to and leave, they've no time for you."

We observed that staff did not support people to be understood or to express themselves. We observed that staff did not sit patiently with people that needed time to speak and to be understood. Pictures used to support people's communication were pinned to a noticeboard but staff told us that no one living at the home at the time of our inspection used them.

People were not always treated with respect and dignity, this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not tell us how they were involved in decisions about their care and by looking at records we saw that people were not involved in planning their care. Following the inspection records were shared with us that showed that people were involved in consenting to their care plan. When speaking to a person about personal care, they told us, "No, I don't think they ask, they know what needs to be done and they just get on with it." Care provided was not personalised and instead focused on providing personal care rather than on understanding people's needs, preferences or choices.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care or were supported to spend time how they wished. A person told us "My family visit whenever they can and take me out." Four people we spoke to told us that family members visit them and take them out. One person told us "No I don't join in the activities, there's not much goes on anyway." One person used a mobility scooter and went out independently.

People were not supported to participate in activities of their choice or pursue hobbies. We spoke to three people, in their rooms, who told us they spend almost all their time in their rooms and felt isolated but did not feel encouraged to go to communal spaces as there were no activities going on. When a person was asked why they were in their room and not in the lounge the person told us "Well first they'd have to be prepared to move me down there. They wouldn't do it." One person had a hoist in their room, staff told us that no one uses a hoist and people will use a stand aid. Following the inspection records were sent showing events such as a Queen's birthday party, film club and gardening club with photographs of people taking part.

Activity records showed that people's activities were sitting in the lounge, watching the TV and chatting. People have family visitors and one person employs a person to take them out shopping every fortnight. Activities are coordinated by care staff, people told us that there are not many activities. Records showed that a weekly structured activity programme was in place and people were asked for feedback in resident's meetings on activities. Records showed that people were supported to maintain relationships with relatives and loved ones and people told us that their family visited them.
A person told us they enjoy bowls and watching sport on the TV, their care plan did not talk about any activities the person told us they enjoy. There was a timetable of activities displayed on a noticeboard in the dining room including hairdressing and bingo. The senior carer told us that they did activities with the people as their workload permitted and people consistently told us that no activities had taken place. A person told us "There aren't any activities that interest me." After the first day of inspection activities charts for each person had been introduced which recorded what activities the person had been involved in.

People's daily care notes focussed on health and did not talk about social needs or activities. Staff wrote the same thing every day which was not personalised and focussed on personal care. Staff told us they encourage people to be independent in their personal care. The care was not adapted to meet an individual persons physical or emotional needs. People who had emotional and mental health needs were not being supported by staff, for example one person's care plan stated that the person can be distressed but did not give guidance to staff about how to support that person. Staff were reliant on support from external teams to support people's emotional wellbeing or behaviours.

People did not receive the care and treatment to meet their assessed needs or which reflected their preferences or wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff followed the provider's complaints process and complaints were investigated and resolved.

Complaints records were seen and performance reviews following complaints were seen in staff files. Records showed us that the management investigated and resolved this complaint. Another person told us, "I've never had to complain, I would talk to one of the girls if anything was wrong. I have friends who come and take me out sometimes but I don't join in anything here unless I have to." Another person told us "I've never complained but I would have a word with the senior carer if I had problems." The complaints policy was displayed. Staff told us they knew what to do in accordance with the complaints policy.

Several people had religious needs which were documented from information shared by relatives in their care plan as a religious preference. A staff member told me that a person is visited by representatives of their religious community which is organised by the person's family.

People were supported to receive care and treatment up to the end of their lives in the home where staff could continue to support them. Staff were given end of life care training externally and had a good understanding of the personal care needs of someone who is on end of life care.

Requires Improvement

Is the service well-led?

Our findings

On the days of our inspection the registered manager was away, the registered manager had informed us this absence. We spoke to the deputy manager, who was the person in charge who oversaw the day to day running of the home in the registered managers absence. Not all arrangements made for the manager's absence were effective. Staff were not equipped by the provider to run the home in the absence of the registered manager for example the staff member in charge was not able to describe actions to take if there was an incident, when to raise a safeguarding alert to the local authority and was not sure of what incidents were notifiable to the Care Quality Commission (CQC) or to other authorities. The registered manager had made arrangements to ensure resources and food orders were in place in their absence but other systems were not in place. Some important documents and records were not readily available to the person in charge who would need access for the day to day running and governance of the service, these were documents we needed to see so the provider was given an opportunity to make the documents accessible and were made available to the inspection team later. Staff told us the registered manager and provider were not based at the service and visited once or twice a week and people told us they did not know who the registered manager was.

People were not always protected from the risks of harm by out of date risk assessments records. Staff did not use risk assessments as a way of monitoring and managing risks to support people to stay safe and respect a person's freedom. Risk assessments were in people's care plans but information was out of date or not reflecting the current needs of the person. For example, in one person's care plan there was a risk assessment for using a stand aid but the person had full mobility and did not use a stand aid. Another person's risk assessment for mobility said that the person requires support to walk with one member of staff. During our visits the person was observed using a wheelchair. Staff told us that the person uses a wheelchair most of the time and the care plan said the person uses a wheelchair. Staff told us they kept up to date on people's needs by reading care plans, sharing information at handover before every shift where they visit each room, check the persons daily notes and check medicine records.

The managers carried out a range of audits and checklists, where these identified issues or areas of improvement these were not acted on to improve the quality of care provided or learn from mistakes. For example, although we saw some audits and tracking of incidents such as falls and accidents these did not identify learning or preventative measures. Audits looking at infection control picked up on issues such as open bins in bathrooms with waste equipment inside, the audits did not then lead to management action to mitigate the risk of cross infection. Records for monthly building, cleaning rota's and room checks were seen, records showed that checks had not been recorded every month and when issues were identified no action were taken to resolve the issue.

There was an inadequate process for assessing and monitoring the quality and safety of the care provided and records in respect of each person's needs were not kept accurate or up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications which the provider was required to send CQC by law, had been completed as required. The

provider had displayed their last inspection rating clearly in the home.

The culture of the home was observed to be task focussed and not always person-centered and people were not treated in a respectful way. There was a range of policies but these were not always effective, for example there were unclear processes for raising safeguarding concerns.

A satisfaction survey is sent out annually to relatives, residents and visitors. Team meetings and resident meetings were held every other month. Staff told us that residents are encouraged to take turns to chair the resident meetings, minutes showed that this had happened in some meetings.
Compliments were read from relatives, which include "Thank you for arranging a delightful and entertaining Xmas party for residents and relatives. We enjoyed the food and music very much." Another compliment said, "Thank you for making Mum's birthday a great day and making us feel welcome".

External professionals told us that the staff work in partnership with other agencies. The service has participated in the National Care Home Open Day for the last three consecutive years.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy, dignity and independence were not respected throughout the service or promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to care and treatment was not assessed robustly and procedures to make best interest decisions were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the risks of harm or infection. Staff did not always use safe practices. Systems were not in place to evacuate people safely in an emergency.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered manager had not made arrangements for the governance of the home in their absence.