Greensleeves Homes Trust

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

Summary of findings

Overall summary

Gloucester House is a nursing home that was built in 1990, situated in Sevenoaks, providing en-suite accommodation for up to 57 people some of whom live with dementia. There had been a change of ownership by a new provider in June 2015.

The service is split in four wings ('villages') across two floors connected by a lift and each village accommodates up to 12 to 14 people each. There were 49 people in Gloucester House at the time of our inspection, 43 of whom had nursing needs and 27 of whom lived with dementia. Not all of the people living in the service were able to express themselves verbally and communicate with us.

This inspection was carried out on 03, 04 and 07 March 2016 by three inspectors and an expert by experience. It was an unannounced inspection.

There was a new manager in post who was registered with the Care Quality Commission (CQC) since June 2015. 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.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

People, relatives and staff told us there were insufficient staff deployed to consistently meet people's needs. Staffing levels had not been calculated taking into account the dependency and complexity of needs for people living with dementia and who may have nursing requirements or behaviours that challenge.

There were thorough recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect. People were able to spend private time in quiet areas when they chose to.

The premises needed re-decorating and this was planned to take place following the conversion and

renovation works planned over the next 12 months.

Staff had not yet received all essential training although this training was in process and monitored to ensure its completion by all staff within a set time frame. All members of care staff received regular one to one supervision sessions. Nursing staff had not yet received this support; however a newly appointed deputy manager had scheduled this to take place.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they helped them. However people's mental capacity was not assessed nor documented appropriately when necessary about particular decisions; meetings with appropriate parties were not held or recorded to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences and restrictions.

People's individual assessments and care plans were reviewed monthly or when their needs changed, although not all people's care files were up to date. There were plans for key workers to involve people at monthly reviews and invite their relatives or legal representatives to participate in annual reviews that were scheduled.

Clear information about the service, the facilities, and how to complain was provided to people and visitors.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People were involved in the planning of activities that responded to their individual needs. People's feedback was actively sought at relatives and residents meetings. However a satisfaction survey carried out four months ago by an external assessor had still not been returned and analysed.

Staff told us they felt valued by the registered manager and they had confidence in her leadership. The registered manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service.

There was a system of monitoring checks and audits to identify the improvements that needed to be made. The management team acted on the results of these checks and was in the process of making changes to improve the quality of the service and care.

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 consistently safe. There was not a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe.

Medicines were administered safely although some people received their medicines later than prescribed due to staffing levels.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

There was an appropriate system in place for the monitoring and management of accidents and incidents.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Safe recruitment procedures were followed in practice.

Is the service effective?

Requires Improvement

The service was not consistently effective. Approximately one third of the staff had not yet received all essential training although they were scheduled to complete this training in June 2016. However staff had a good knowledge of each person's plan of care and of how to meet their specific support needs.

Although staff were trained in the principles of the Mental Capacity Act 2005, these were not appropriately enforced in practice. Appropriate assessments of people's mental capacity and best interest meetings were not carried out and documented when necessary.

The registered manager understood when an application for DoLS should be made and how to submit one.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when

needed.

Is the service caring?

Good

The service was caring.

Although staff were not consistently able to respond to people's needs promptly due to staffing levels, they communicated effectively with people and treated them with utmost kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's individual needs. Staffing levels meant that staff were not consistently able to respond to people's needs promptly. Not all of people's care files had been transferred to the new provider's systems of documentation and some of the care plans had not been updated to reflect people's current needs.

People or their legal representatives had not been routinely invited to be involved with the review of people's care plans

The delivery of care was in line with people's care plans and risk assessments.

People's care was personalised to reflect their wishes and what was important to them.

A daily activities programme that was inclusive, flexible and suitable for people who lived with dementia was implemented.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Requires Improvement

The new registered manager had led improvements in the service since they had been in post, and the new provider had set up new quality monitoring systems. However these monitoring

systems were not yet embedded and sustained over time, and had not detected the shortfalls that we identified during our inspection.

The new registered manager placed people and staff at the heart of the service. Emphasis was placed by the management team on continuous improvement of the service. There was an open and positive culture which focussed on people.

The registered manager welcomed people and staff's suggestions for improvement and acted on these. Staff had confidence in the registered manager's style of leadership.

The staff told us they did not feel valued by the provider due to the staffing levels in place.

Gloucester 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 carried out 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 was carried out on 03, 04 and 07 March 2016 and was unannounced. The inspection team consisted of three 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. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people who live with dementia.

The provider had completed a Provider Information Return (PIR) prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered the PIR and looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events.

We looked at 15 sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 20 people who lived in the service and 11 of their relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also 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 the operations manager, the registered manager, the deputy manager, the activities co-ordinator, four nurses, eight members of care staff, the maintenance manager, two members of kitchen staff, one laundry assistant and a person responsible for the maintenance of the premises. We also

contacted two local case managers who oversaw people's care in the home. We obtained feedback about their experience of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe however all the people we spoke with told us they were dissatisfied with the number of staff that were deployed in the service to meet their needs. They told us, "I do feel safe with the regular care workers, they are friendly and kind, I just wish they had more time for us", "I think the staff are stressed because they have so much work to do but they are ever so caring", "It is not the place it was, everyone is so rushed now", "The staff are so busy and stressed they can't give us as much time as before like when the place was owned by another organisation", "The staff are really kind when they get to you but often we have to wait a long time before they can come because they are overworked, there is not enough of them." A person told us, "I really want to go out to the gardens but they don't have enough staff to take me." Two relatives told us, "Often in the evening you cannot see any staff around, all it takes is for the nurse and two care workers to be busy with one or two persons in their bedrooms, the others just have to wait" and, "Lovely staff, just not enough of them especially for looking after persons with dementia."

Staffing levels were not sufficient in meeting people's complex needs. The service is divided in four wings ('villages') across two floors and each village accommodates 12 to 14 people each. There were 27 people who had been diagnosed as living with dementia, and five people who displayed signs of confusion or memory loss. Forty-five people had nursing need. Thirty people needed two care workers to help them move around with the use of specialist equipment; three people lived with Parkinson's disease; two people had a catheter, one person had an artificial opening for their urinary system; seven people displayed behaviours that challenged and needed to be supervised at regular intervals; one person had a pressure wound. At night, a person whose skin integrity was at risk needed to be repositioned to ensure their skin was protected.

One nurse was deployed per floor during the day and at nigh time, overseeing up to 27 people across two villages. On each floor the nurse was assisted by six care workers in the morning, four in the afternoon and two at night. To cover vacancies and staff absences, the service employed three nurse bank staff, two care workers bank staff and agency staff. The same agency staff were used as much as possible to provide continuity. However, all the people, staff and relatives we spoke with told us there was not enough staff to meet people's needs. Care workers told us they were at their busiest in the morning as they had to collect breakfasts from the kitchen, serve each person and return crockery. They also manned the tea trolleys and served tea and coffee throughout the day. Care workers provided activities at weekend when the activities coordinator was not on duty and re-located clean laundry in each person's room. Staff told us, "Mornings are the busiest times as this is when people need help with toileting and getting dressed and we simply do not have time to tend to everything we have to do while we do housekeeping duties and ensure people are up, washed and dressed in time." Another care worker said, "We have to interrupt personal care to do the tea trolleys mid-morning then help residents at lunch, in this village alone four people need help with their food, then we have to do the daily notes before clearing plates and do tea trolleys again so often personal care does not get finished." A relative told us, "When I come to pick up my wife at 09:30 to take her to church, often she is not ready, has had no breakfast nor has had her tablets yet."

One laundry assistant ensured all laundry tasks were carried out five days a week. The laundry assistant

processed eight bags of laundry daily that included soiled bedding and slings, ironed garments and pressed sheets. One bank staff or housekeeping staff covered laundry duty for two hours on Saturday, and no cover was arranged for Sundays. One relative told us, "It takes up to seven days for the laundry to be processed; once a care worker had to go in the laundry room late at night and rummage for a nighty as my relative had run out."

One person who remained cared for in bed told us that care staff did not consistently come and visit them often enough during the day to check on their wellbeing and chat to them if they needed company. They told us, "I stay in bed all day and one care worker comes once a day to check on me if I am lucky, there are simply not enough of them around for all of us." Another person said, "If I need help going to the toilet, it can take up to one hour for someone to finally come and help me. This is not because they don't care because they do without a doubt, but they are always so rushed; there is not enough staff available." However a person told us, "If they can't come straight away they pop in to explain and say sorry we will be with you as soon as we can, and they do when they can." A member of staff told us, "We really would like to spend more time with our residents but one to one time is a real luxury here; for example each of the day staff can only provide one shower a week per person, on a good week." The night staff showered or bathed approximately three people per floor every night. A care worker told us, "We are so rushed all the time, our shift is 12 hours non-stop; this village is a high dependency unit; at 5.30pm it is supper, tea run, bed, bed, bed."

Each morning the nurse checked each person on the floor to see if anyone needed a visit from a GP, and participated in handovers from earlier shifts before starting the 'medicines round'. We observed the nurse administering medicines in the morning in two villages and this task took three hours so the nurse was not available for other tasks until lunchtime. Two other nurses confirmed this to be a daily occurrence due to the amount of medicines to be administered and to being interrupted during their rounds for nursing care. We discussed this with the registered manager who told us that they were working with the local pharmacist to see how some of the medicines could be administered later in the day. A nurse told us how they stayed later than their paid shift to finish updating care plans. They said, "It can take a whole afternoon to update four care plans, we don't get a break, we try to beat the clock."

We were told that should any concerns or emergencies needed urgent attention from a nurse who was already responding to a person's needs, the nurse from the other floor would come to help. However this would leave a floor unattended by nursing staff. Staff told us, "Since the new provider took over the service, the number of nurses has been halved. Ideally we need one nurse per village especially as people with dementia definitely need more attention and more time for any daily living task." Our observations and what people and staff told us supported this.

We discussed with the registered manager and the operations manager the staffing levels. They told us the ratio of staff to the number of people matched the provider's policy. However the dependency and complexity of needs for people living with dementia and who may have nursing requirements or behaviour that challenge had not been appropriately calculated to determine how many staff should be deployed. Although people using the service had not experienced a negative impact on their health and welfare, there was not enough staff consistently available to respond promptly when people needed help, nor respond to a possible emergency to keep people safe. As a result, people's needs were not consistently met.

The failure to ensure sufficient staffing is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. There was a detailed

safeguarding policy in place in the service that reflected local authority guidance. This included information about how to report concerns and staff knew they should report to the local authority or the police if necessary. Staff were aware of the whistleblowing procedure in the service and staff we spoke with expressed confidence that concerns would be raised.

The premises were safe for people because the home, the fittings and equipment were regularly checked and serviced. Safety checks had been carried out throughout the home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, water temperature, Legionella testing, service logs relating to the lift, appliances and fire protection equipment. Equipment that was used by staff to help people move around was checked and serviced annually. Portable electrical appliances were checked regularly to ensure they were safe to use. Regular checks were also made on the minibus to ensure that it was safe and in good condition. There was a pest control contract in place for the home that meant that the risk of harm from pests was mitigated. Each person's environment had been assessed for possible hazards. People's bedrooms and communal areas were free of clutter. A security system ensured that people remained safe inside the service and people were assisted or accompanied by staff when they needed or wished to leave the building.

There were plans in place that detailed how people would be kept safe in case of an emergency. There was a fire risk assessment of the overall premises. An appropriate business contingency plan addressed possible emergencies such as fire, evacuation, extreme weather and outbreak of disease. People who lived in the service had personal emergency evacuation plans in place. These were available to staff and emergency services in an accessible location and showed the level of support that people required to evacuate the premises. Staff had received fire training and drills were regularly carried out and documented in order to ensure that staff had the skills and training to respond to an emergency. There was appropriate signage about the exits. There were regular checks of the fire warning system, fire doors, emergency exit doors, break glass points and emergency lighting.

There was an effective system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. Most repairs were completed on the same day as they were reported. The home employed a full time maintenance manager and staff were positive that any issues they reported would be dealt with promptly.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from reoccurring. Appropriate logs were completed by care workers, assessments were carried out by the nurses and all relevant information was forwarded to the registered manager who analysed it on the day. The registered manager carried out monthly audits and compared them to previous audits to identify any possible trends or patterns. These audits were further monitored by the Operations Manager on a monthly basis.

Risk assessments were centred on the needs of the individual. Staff were aware of the risks that related to each person. An assessment for a person who was at risk of falls included consideration of their diet, clothing, exercise, mobility, hearing, continence, medical condition and mental health. This person had been referred to the physiotherapist and staff were aware of how to help this person move around. Following risk assessments, several people had been provided with bed rails at night to minimise the risk of falls; a person who lived with Parkinson's who often fell on their knees was provided with special knee pads at their request. These assessments were reviewed during 'monthly evaluations' and updated when necessary. Staff helped people move around safely and people had the equipment and aids they needed within easy reach. People had individual slings that matched their size and requirement. One person's sling

needed to be replaced to reduce pressure on their skin and the physiotherapist had been consulted to identify the best sling.

Medicines were managed appropriately within the home in order to ensure that people received their medicines as prescribed. There was a clear medicines policy in place. This included information about how to report and manage any medicines errors that had occurred. Staff were aware that they would need to report errors and how and when to seek additional medical advice when required. Stock levels were managed appropriately and there was a sufficient supply of medicines available. Medicines that were no longer needed were disposed of appropriately and records were maintained to ensure all medicines that came into the home were accounted for.

Medicines administration records (MAR) were completed appropriately. Medicines records included a photograph of the person as well as information about any allergies they may have to particular medicines. Information was included in the MAR sheets concerning the protocol for administering 'as and when' required medicines such as homely remedies. The competence of staff who administered medicines had been checked and staff had been assessed as competent. The assessments included observation of practice. Regulation reviews of medicines were completed by the GPs who supported the home.

There was an infection control policy in place that provided clear guidance for staff concerning the steps they should take to protect people from the risk of infection. It had been identified that an infection control lead was needed for the home and the deputy manager had been delegated this task. Audits had been carried out to identify any potential risks and actions that needed to be taken in relation to infection control. For example, it had been noted in the previous audit that curtains within the home needed to be on a cleaning schedule to ensure that they were regularly washed. This had been implemented. It was noted in the home's infection control policy that a spill kit was required to safely manage spills of bodily fluids. However kits were not available at the time of the inspection. Staff told us they would use soap and water to clean any spills of bodily fluids. The manager told us on the day of the inspection that she would ensure that kits were ordered so they were available for use in accordance with the service's policy.

Appropriate checks had been carried out to ensure that staff recruited to work in the service were suitable and of fit character. Checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work there. Staff members had provided proof of their identity and the right to work and reside in the United Kingdom prior to starting to work at the home. For example, we saw that a staff member had provided their biometric residence permit as evidence of their right to live and work in the United Kingdom. References had been checked before staff were appointed and where possible references had been taken up with the previous employer. Checks were made that nurses employed by the service had current professional registration and systems were in place to allow on-going monitoring.

Disciplinary procedures were followed and action was taken appropriately by the manager when any staff behaved outside their code of conduct. The disciplinary procedure had been followed in relation to concerns about the practice of a particular staff member. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Requires Improvement

Is the service effective?

Our findings

People said the staff gave them the care they needed when staffing levels allowed them to do so. People told us, "They are ever so efficient but they have to work fast because they can't stay long", "They are very efficient and they know me well", "I get what I ask for, even if sometimes I have to wait" and, "The food is always nice and tasty." A relative told us, "The staff are definitely very knowledgeable, they understand how to get the best of my relative" and, "When we manage to talk to a nurse or a care worker, they are always very receptive and willing to help, even when they are so busy." A case manager who oversaw people's care in the service said, "Some people still report that it can take time for the call bells to be responded to."

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options for each individual.

Staff were trained in the principles of the MCA and the DoLS and were able to tell us about the main principles of the MCA. However, the requirements of the MCA were not properly applied in practice under the new provider ownership. The new provider had supplied in all people's care files a template titled 'Mental State and Decision-Making' for staff to use. This template listed 15 domains including self-medication, having a room key, freedom to leave home unsupervised, use of alcohol, recreational activities and advance decisions about death and dying. Opposite each domain there was a tick box where anonymous staff had entered either 'Y' or 'N'. There were no individual documented mental capacity assessments to show how people's mental capacity had been assessed regarding each specific decision, nor of any meetings having taken place to reach a decision in their best interest. For one person who received their medicines covertly, a nurse had filled in part a template from the local pharmacy to record the decision that had been taken on the person's behalf. However this was not dated, and there were no records to indicate a relevant mental capacity assessment had been carried out. The person's legal representative had agreed to the decision; however this had not been appropriately recorded.

People's mental capacity had not been assessed when they lived with dementia or when they experienced confusion, in regard to their ability to use their call bells for help, for consenting to the use of bed rails, nor for their ability to understand and consent to their care plan. A member of staff told us, "We would be glad to do it properly if only we get proper guidance about how to do this and were given templates to use, as it is

we follow the templates we are given." A document regarding Cardio Pulmonary Resuscitation (CPR) had not been appropriately completed by a GP in regard to their mental capacity and the staff had not identified this error. There were two different handwritings on the document and only one signature. Although people using the service had not experienced care that has had a negative impact on their health, quality of life, personal rights and welfare, as records of mental capacity assessments and of related meetings were lacking, people could not be confident that legal processes were followed and that appropriate decisions were taken in their best interest.

The failure to consider and act in accordance with the MCA is a breach of Regulations 11(1) (3) of the Health and Social care Act 2008 (regulated Activities) 2014.

Staff sought consent from people before they helped them move around or before they helped them with personal care. A person told us, "The workers are polite; they check it is OK with me."

The registered manager had ensured that all staff was scheduled to attend essential training, as soon as she was in post. At the time of our visit, 64% of the staff had received essential training and the training schedule aimed at 95% by June 2016. Staff were reminded when they needed to renew their training. The training offered to staff included dementia awareness. The registered manager told us that training about how to manage behaviours that challenge was included in the dementia awareness course and that all staff were scheduled to attend. They told us, "We don't handle challenging behaviours well and the training will improve staff confidence; 26% of all the staff had received this training so far." Additional training was available, such as end of life care provided by the local hospice team, 'Eden Alternative Associate training' which is about how to combat isolation for people in care homes, and training about how to stimulate people's mind while going out in the garden. The activities coordinator attended the 'Ladder to the Moon' training which is about using original and creative activities for people in care settings. The staff we spoke with were positive about the range of training courses that were available to them.

Care staff were supported to study and gain qualifications for a diploma at level two or above in health and social care. The staff we spoke with told us they were supported by the registered manager to study and gain qualifications. Senior care workers and nurses were encouraged to study for up to level five diplomas. New care staff had a two weeks induction when they started work. This included shadowing more experienced staff before they could demonstrate their competence and work on their own. However there was no documentation that showed that competency checks had been carried out, other than checks for nurses in regard to the administration of medicine. We were told that induction checklists were in progress and that the 'Care Certificate' was about to be introduced for all new staff. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. There was a system of six months' probation check in place, although this had not been used yet.

Staff knew how to communicate with each person. Staff were bending down so people who were seated could see them at eye level. Staff told us how they communicated with a person who did not talk. The person used head movements to express her likes and dislikes and the staff understood this and acted on her wishes. A communication care plan for a person who had visual impairment included guidance for staff about how to communicate effectively with them. The staff followed this guidance and ensured they were heard and understood and escorted the person if they needed to be helped with finding their way around. All staff used positive body language and were smiling when conversing with people. One person told us, "I communicate well with all the staff when they are not rushing around; they are very kind people, although the agency staff are not talking with us much." Staff checked people's hearing aids regularly.

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift twice a day on each floor. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. Additionally there was a communication book on each floor which was used by staff. This system ensured effective continuity of care.

Senior care workers provided regular one to one supervision sessions to care workers. One member of staff said, "This does help us, I can discuss how I feel my job is going." A group supervision with senior care workers had taken place to discuss how to put new care planning systems in practice. Not all nursing staff within the home had had recent one to one supervision. This meant the home was not following their own supervision policy that stated that staff would be supervised at least six times in a year. However, the deputy manager who had been newly appointed had scheduled this supervision for nurses. Additional supervision meetings had been arranged for a staff member when concerns about their practice had been identified and steps had been taken to address issues when they arose.

People praised the food they had and told us they were very satisfied with the standards of meals. They told us, "We have a lovely roast twice a week and a different type of fish each week, always delicious" and, "The food is always nice and tasty." A relative told us, "The meals are always well presented so they are appetising." A senior environmental health officer had inspected the service in June 2014 and had awarded a five star rating in Food Hygiene standards to the service. We saw several people had their breakfast late in the morning as they preferred. We observed lunch being served in the dining areas and in people's bedrooms. The lunch was freshly cooked, hot, well balanced and in sufficient amount. People were supported by staff with eating and drinking when they needed encouragement. The chef had requested juice dispensers to be purchased to encourage people to drink and this had been provided.

Menus were written every four weeks and people were consulted about their preferences. There were two choices of main meal and desserts, and when people changed their mind and wanted an alternative their preference was respected. Alternatives at lunch included options of omelettes, salads, sandwiches, cheese and biscuit and nut roast. Evening meals included home-made soup and two options of hot dishes.

The chef was pro-active and kept a record of options chosen by each person for six months. They told us, "That way, if a GP wants to find out what someone has had for health reasons we can look it up." When people's dietary needs changed, nurses signed a diet notification form for the chef to be aware. The chef and kitchen staff were aware of each person's allergies, likes and dislikes, required portion sizes and whether assistance was required. This information was included in each 'village lunch list' that was displayed in the kitchen. This system ensured that people's nutritional needs were effectively met.

People were weighed monthly and fluctuations of weight were noted and acted on. For example, if people lost a specified amount of weight within a timeframe, they were weighed weekly, provided with a fortified diet, and were referred to the G.P., dietician or a speech and language therapist when necessary.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP or were registered with local GP surgeries, two of which visited the service on a weekly basis. A chiropodist visited every six to eight weeks to provide treatment for people who wished it. People were escorted to their optician or dentist appointments when needed and a visiting optician service provided dementia-specific eye tests that are tailored to each individual. People were offered routine vaccination against influenza.

People had been referred to healthcare professionals when necessary. For example, to a GP, district nurse, tissue viability nurse, and to a memory clinic. When people became unwell, information was promptly communicated to staff at handovers so effective follow up was carried out. This ensured that staff responded effectively when people's health needs changed.

There was signage displayed in the premises for people who lived with dementia. However, only one village where up to 12 people lived had been provided with pictorial aids to help people find their way around, such as personalised bedroom doors. The registered manager told us that extending signage throughout the service featured in their improvement plan.

All bedrooms were en-suite and there were four sluice rooms in place. There was a dedicated hairdressing salon and a library room with free internet available and a physiotherapy room. There were constraints on space due to the layout of people's bedrooms, for example when staff entered and people were standing behind doors to access their wardrobe. Issues with the premises had been identified by the provider and there were plans in place to carry out a programme of improvements including conversions of en-suite to wet rooms to help maximise space. This would ensure that people in wheelchairs would be able to move around more freely in their bedrooms without obstruction. Contractors had been in to visit the home to begin preliminary work and this plan was in process.

The fabric of the building showed signs of wear and tear and most wood work in communal areas including all corridors was chipped. However a full re-decoration programme was planned to take place once the conversions of people's en-suite will be completed. The provider had replaced several fitted carpets and had purchased new comfortable furniture in four of the lounges.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "The workers are all lovely" and, "They [care workers] are a good bunch." One person said, "The workers are ever so busy but they always manage to smile and give you a quick chat nonetheless." Two case managers who oversaw people's care in the service told us, "Staff are helpful and appear responsive to people", "On the whole staff appear friendly and willing to help; families report that staff are good and care for their loved ones in a compassionate and empathetic way" and, "The staff seem helpful and accommodating." A relative told us, "The staff are wonderful." A friend of a person who lived in the service said, "My friend receives excellent care."

Following a staff meeting in July 2015, staff had expressed the wish to "Spend more quality time with residents" and, "More time with residents at sundown and lonely times." However the staff we spoke with told us they were still not able to spend enough time with people who may benefit from more companionship, due to staffing levels. We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. The staff approach was kind and compassionate. They paid attention to how keep people in good spirit. For example, when people had watched a film on Paddington, they had been served with marmalade sandwiches, and people had pancakes throughout the 'Mardi Gras' Day. Care workers went as a group to sing a song to a person in their bedroom when it was their birthday. One person was dancing in the reception area and as they went past, two care workers briefly danced with them. A person who called for help was provided with reassurance by a care worker who knew them well. They told us afterwards, "They are really very good to me."

People were assisted discreetly with their personal care needs in a way that respected their dignity. A person told us, "The workers are kind, they understand how I feel and they cover me when they help me with a wash." A person had complained that her door was left opened by staff when staff helped them getting into bed. This had been remedied. Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality. The premises included a quiet lounge in each of the villages where people could spend quiet times away from other people or meet with their visitors if they wanted privacy. These had been furnished and decorated to provide a comfortable and serene environment for people.

The staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. People followed their preferred routine, for example some people chose to have a late breakfast, or stay in bed. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence. A person had wished to shower independently and staff remained discreetly at close range to assist them if they called for help. Another person wished to dress independently. Staff had respected their wish and had tactfully alerted the person when they wore a shoe on the wrong foot. Staff

placed toothpaste on a person's toothbrush and gave them guidance about how to brush their own teeth. A person had been provided with a key of their balcony for growing potted plants and replenishing a bird feeder, when it had been assessed that it was safe to use. People's relatives were encouraged to take their loved ones out into the community or for a stroll in the garden. Two people had their own car and were able to go out of the premises when they chose.

Attention was paid to equality and diversity. A person who was a Jehovah's witness had provided information to staff about their belief and how they wished to be treated in the service during any emergency intervention. Staff had been made aware of these requirements. People's spiritual needs were met with the provision of a monthly religious service held for people of all faith denomination. Additionally, a catholic priest visited the service weekly.

Clear information about the service and its facilities was provided to people and their relatives. There was a residents' handbook that was being updated with the introduction of the new provider and its philosophy of care. It was printed in large font to help people with visual impairment and included information about the facilities, the fees, the staff team, the planned key workers scheme, social activities and how to lodge a complaint. The complaint procedure was also displayed in the reception area. There was a website about the service and sister services that was informative, well maintained and user-friendly. All staff wore named badges. In each village, the weekly programme of activities was displayed on an information board, in a pictorial format to help people understand what was on offer. There were photographs and names of the staff who were on duty that day. Although menus were not in a pictorial form, this was in progress. In the meantime, people were shown the dishes to assist their choosing.

People were involved in their day to day care when they were able to and when they wished to be. People's care plans and risk assessments were in the process of being reviewed monthly to ensure they remained appropriate to meet people's needs and requirements. The registered manager told us how a key workers scheme was planned to take place in April 2016. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need. There were plans for key workers to sit with people and go through their plans of care with them and to invite relatives and/or people's legal representatives to participate in annual reviews. A person told us, "I am definitely involved with what is going on; I am often asked if everything is to my liking; I told the manager I would get it sorted with the staff if it was not."

People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. Staff were supported by a local hospice palliative team with whom they worked in collaboration to ensure people remained pain-free and comfortable. Therefore people could be confident that best practice would be maintained for their end of life care.

Requires Improvement

Is the service responsive?

Our findings

People gave us mixed feedback about how the service was responsive to their needs. Two people told us, "I really want to go out to the gardens but they don't have enough staff to take me" and, "I would like to be taken for a little stroll everyday but I don't like to ask because I know they are busy." A member of staff told us, "If we had more time we could take some of the residents out to the garden for some fresh air." A relative told us, "The staff are lovely and yes they respond well to my relative's needs whenever they can although in the evening it can take a longer time for them to come." People were very complimentary about the activities provided and about the activities coordinator. Their comments included, "She is very good, and she makes my day happy one", "Great activities, always jolly". People told us they enjoyed the food and said, "Lovely meals, very nice" and, "They cook what I like and what I want."

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments included an outline of people's life history and their likes, dislikes and preferences over their care and lifestyle. There were clear accounts of people's needs in relation to their communication, mobility, skin integrity, nutrition, health and medicines. This information was included in an initial care plan that was in place when people moved into the service. Individualised care plans about each aspect of people's care were developed further within six weeks, as staff became more acquainted with people, their particular needs and their choices. One person had displayed behaviours that challenge and more difficulty with moving around than originally assessed. Their care plan had been updated to reflect this and additional risk assessments relevant to these needs had been introduced. One person's legal representative had been invited to participate with the development of their care plan and attention had been paid to their comments.

People were encouraged to personalise their bedrooms as they wished and bring their own articles of furniture to make them feel at home from the beginning of their stay. They were able to bring pets in the service and the registered manager told us how a person's cat was soon to come into the service to live with their owner.

The registered manager and operations manager told us that they were in the process of transferring all the people's care files in the service that were pre-existing the change of provider unto a new improved system. Each time a person's file was transferred, there were checks to ensure that it was appropriately updated and that all documentation was complete to reflect accurately people's needs, relevant risks and clear guidance for staff. Only 27 files out of 49 had been transferred to the new system.

The registered manager carried out a routine review of people's care plans six weeks after they came into the service. They told us that care plans were routinely reviewed and updated by staff every four weeks thereafter. We looked at eight new files and found that seven had been appropriately completed and updated monthly to reflect people's needs. One new file had not been updated to reflect that a person had acquired skin damage and we discussed this with staff and the registered manager who ensured a body map, a risk assessment and a specific care plan was included without delay. We also discussed with the registered manager and operations manager how people's mental capacity was not appropriately

documented in any of these files. Out of seven files that had not yet been transferred, four had been updated quarterly only and three had not been updated for three months. However, when one person had displayed signs of anxiety about another person in the service, action had been promptly taken to safeguard this person and to update relevant documentation. A case manager who oversaw people's care in the service reported, "On my last visit I identified a lack of documentation of care workers' notes." Staff told us they did not have 'protected time' to transfer files into new templates and update people's care plans and risk assessments and that they fitted this task within their busy schedule. They told us, "There is not enough time in the day, not enough of us to do it all including paperwork and people's care comes first."

Although the service satisfaction survey indicated that 79% of people had acknowledged that they had 'a real say' in how staff provided care and supported them, There was no evidence that people or their legal representatives were routinely invited to be involved with the review of their care. On review templates, there was a section to record 'resident's views' and although staff had written that residents were satisfied about their care, six people we spoke with could not recall staff sitting with them and asking them their views about aspects of their care plan and about how it was delivered. One meeting had taken place with a person's family, although this was instigated by the family. Another meeting to review a person's care where a person's family and an advocate had been invited had been set up by the local authority. The registered manager told us, "We have not been pro-active in regard to annual reviews although we plan to involve people and their families more." Their plan included inviting people's families or legal representative with their consent, to formal annual reviews of their care plans. It also included a 'Resident of the day' scheme, starting 01 March 2016, when people's key workers ensured their care files were complete and updated, bedrooms were deep-cleaned, clothes were named and laundered, toiletries were in place and individual requirements were met.

People's likes, dislikes and preferences were taken into account. Staff enquired with people what they liked, disliked, and noted their preferences about routine, activities and food. The chef told us they did "A table tour of the dining room a couple of times a week" to check whether people enjoyed the food and took note of people's comments to inform their menu. One resident requested liver and bacon and this had been put on the next menu. There were care plans for people's daily routine such as for morning and evening care, lunch and supper. These included details of when a person liked tea at a specific time in the morning, preferred their meal on a small plate, and that they did not wish to be disturbed beyond a specific time at night. People's particular interests were noted, such as what type of books people enjoyed reading, when they liked doing crosswords, reading a particular newspaper or when they liked to walk around the service. One person disliked watching television or listening to the radio. We asked three members of staff to tell us about people's preferences and they were aware of these.

People had an opportunity to give their feedback about the quality of the service. Relatives and residents meetings were held monthly and people were invited to comment on any aspect of the service including activities and food. These meetings were scheduled alternatively on a Wednesday and on a Saturday to allow people who worked on weekdays to attend. At the last meeting, a person had requested to be escorted to the bank and this was implemented; a person had requested they grow their own rhubarb to make rhubarb 'crumble' and this had not been implemented although there were plans to involve people in outside activities and gardening as soon as the weather permitted. As a result of people and their relatives comments, a person now ate their meal in the lounge as they wished, a trellis on a garden wall had been erected, and the registered manager had introduced a daily cleaning checklist for staff to complete.

A survey had been carried out in October 2015 by an independent market research organisation that provided questionnaires to the service. Two volunteers had been coached on how to support people with completing these and had been provided with pictorial aids to gather people's feedback. Although the

completed questionnaires had been sent back to this organisation in October 2015, the service had not yet been provided with the results. We discussed this with the registered manager who requested the results without further delay; however these had not been obtained at the end of the third day of our inspection. As results of satisfaction surveys took at least four months to be analysed, people could not be confident that their feedback would be considered in a reasonable timescale.

An internal staff survey had been carried out in February 2016. Staff had been invited to comment on the service anonymously if they preferred and 45% of the staff had completed a questionnaire. The completed questionnaires were analysed by the Human Resource team, however the results had not yet been returned to the registered manager for their consideration. There was a comment box in reception area that people, relatives and staff could use and which was emptied weekly by the registered manager.

There was a system to gather feedback from stakeholders and healthcare professionals who visited the service. They included social workers, the local hospice team, GPs, chiropodists, dentists and local pharmacists. The last survey had been carried out in October 2015 and the results of seven completed questionnaires had been analysed to show a good overall level of satisfaction, although there were comments that were not positive and that related to staffing levels. These included, "Residents are on their own in the dining room in the evening", "When office staff away at weekends there is no-one to greet visitors", "Residents have to wait for breakfast", "More staff resources needed to allow clients to be enabled and empowered", and, "I understand recruitment and budget are important factors but it can work, with a little help the staff could achieve so much more." However staff had not been increased as a response to these comments.

Other comments about "People not using the garden enough" had led to the creation of a children play area, a picnic area and the allocation of a budget for raised flower beds and a scented garden to be used in the summer. Additionally, staff had been booked on a training course titled 'Why don't we go in the garden' that provided imaginative ways about how staff could engage people in the garden. As a result, there were plans to take people out into the gardens on a regular basis if they so choose, in the summer.

Staff placed emphasis on the promotion of good health. The service employed two physiotherapist and one physiotherapist assistant who all worked part-time. This staff had assessed each of the people who lived in the service and had fed back to the registered manager their concerns about the number of people who remained for long periods of time in their bed or in their 'Hydro flex' water chair. Additionally, a comment from a stakeholder stated, "Too many people are sitting statically in their 'Hydro flex' chairs, not enabled." As a result, the physiotherapy staff had devised a physiotherapy programme to get people out of bed in personalised wheelchairs and had obtained equipment that enabled people to cycle using their arms and legs. A relative told us, "Best time I've seen my relative use his arms for years." A virtual tour of 'Lands' End to John o' Groats' with goals to achieve had been set up so that people's exercise could be measured and they could see how much they walked or cycled.

A range of daily activities that were suitable for people who lived with dementia was available. There was an activities coordinator during the week that additionally came once a month on a Saturday. People were involved in the planning of the activities programme. The activities programme was written weekly and people and their relatives were consulted at monthly relatives and residents meetings about what they enjoyed doing. The activities coordinator also had consulted people's files to find out about their life history, interests and hobbies. Three people used to enjoy football and the activities coordinator had formed a group so they could talk about football and watch matches together. Another person liked to colour books and the activities coordinator had obtained colouring books and pencils, and had encouraged five other people to join this new activity. A person who was a keen gardener was arranging flowers in the

service. Another person helped a volunteer taking a shopping trolley to each of the bedrooms. As a result of people's feedback, a new activity of 'Pub Afternoon' had been introduced, where people could sing-along, play dominoes and drink shandy.

The activities provided included crossword, reminiscence games, armchair exercises, table top games, making music, quizzes, sing along and bingo. All activities were subject to people's choice. At weekends, care workers provided activities such as 'Sherry and nibbles' gathering, Bingo, and watching 'Songs of Praise' on television or watching a DVD. Special days including people's birthdays were celebrated. For example, on St David's Day and St Patrick's Day, the menus were written in Welsh, and Welsh and Irish music was played; an Irish menu had been served; on Remembrance Day, staff wore costumes and encouraged people to dress up; a Chinese meal was served on Chinese New Year, and people had created special decorations for the service during 'arts and crafts' activity for Valentine's day. There were planned celebrations of the Queen's 90th birthday. External performers visited the service such as singers, pianists, a cellist, and theatre company. A 'Pat dog' service visited people regularly and people could pet the 'resident rabbits' whenever they chose. A care worker said, "The rabbits are lovely and they have a calming effect on some residents."

The activities coordinator told us that they "Tried to visit residents who stay in their bedroom at least once a week for half an hour, to talk or read aloud." They took the activities programme and menus to each person in the service at the beginning of the week and checked whether they needed anything and whether they wished to join the activities. If they wanted to participate, the activities co-ordinator of a care worker brought them to the lounge. However, three people who stayed in their room told us that this seldom happened. A relative told us, "I would like to see my relative do more and see her out her room more but I feel the care workers don't have the time." A member of staff told us, "A lot of care workers would like to do more with the residents but there is no time; the activities coordinator tries to get everyone on board but there is only one of her."

The activities coordinator was pro-active and researched on activities suitable for older people who may live with dementia and consulted specialised websites such as 'Active Minds'. As a result, activities equipment had been purchased including sensory packs, to vary the activities programme and stimulate people's mind. They regularly attended an online forum with other activities coordinator and met colleagues from sister homes to exchange new ideas.

There was a limited programme of outings provided by the service, due to a lack of available drivers to drive the service's minibus. A person told us, "We don't go out much at all, especially if we don't have family to take us out." Two care workers held the appropriate licence although one's licence was due to expire in May 2016. Driving tasks were not allocated in their staff rota and were carried out beyond their working hours. We were told that "As we are short of staff the 'drivers' have to come on their day off so we rely on their good nature." The minibus could hold three people and three care workers including the driver so several journeys were needed to give each person the opportunity to go out on a trip. There had been one outing to garden centre and one trip to the local shopping mall at Christmas. The registered manager told us the provider was considering the purchase of a mobility car to supplement the minibus and that this will improve the frequency of outings opportunities for people. However this was not yet implemented.

People were aware of how to make a complaint. The complaint procedure was displayed in evidence in the reception area. Complaints that had been lodged since the new provider took over the service had been addressed as per the service's complaint policy. A relative had complained about staffing levels as they were unable to locate staff when they visited during the evening. As a result, although staffing levels had not been reviewed and increased, signs titled 'Care in progress' had been introduced and displayed on people's

doors to indicate where staff could be found if they were busy attending to a person in their bedroom. A person told us they would not hesitate to complain to the manager if they had any problems and that "She would definitely sort it out".

Requires Improvement

Is the service well-led?

Our findings

The registered manager walked around the premises each day to get an overview of the day to day running of the service. These checks were recorded in a daily 'walkabout sheet'. Records indicated that checks were made of the premises and its level of cleanliness and of staff practice. The registered manager talked with people's relatives and took action on the day when they voiced any concerns. However some of the people told us the registered manager was not visible in the service enough for people to get to know her and speak with her. People told us, "What new manager, I never see her" and, "She doesn't come round to see us, if we want to see her or ask anything we go to her." The registered manager told us they were aware of this and planned to move their office from the first floor to the ground floor in order to be more accessible and connect more with people.

Staff were positive about the support they received from the registered manager. They reported that they could approach the registered manager with concerns and that they were confident that they would be supported. They described them as, "Approachable", "Understanding and kind." The registered manager had supported staff when morale was low and had promoted a philosophy of care based on mutual respect of each other and of each person who lived in the service. They had briefed staff about the importance of maintaining high standards of behaviour and practice and had brought a poster that reads 'TEAM', standing for 'Together Everyone Achieves More', which was displayed in the staff room. One staff member told us, "We will be supported if we ask for help." Staff were positive about the improvement planned for the premises. One staff member told us that the provider had "Big ideas" and were enthusiastic about the planned improvements.

The registered manager held regular staff meetings and encouraged the staff to be involved with the running of the service. Following a staff meeting in July 2015, staff had been invited by the registered manager to write on a note the improvements they would wish to see in the service and stick their note on a 'wall of wishes'. The notes had been collected and analysed by the registered manager. As a result from this feedback, the registered manager had implemented several improvements that had included a pay rise for staff, the purchase of new equipment and crockery, face to face training for staff to replace E-Learning, and the inclusion of care staff at nursing staff handovers. Out of 28 notes, nine were about staffing levels and included, "Extra care worker on each village", "Allocated time to do care plans", "Spend more quality time with residents", "Giving residents time", More time with residents at sundown and lonely times" and, "Staffing levels especially nurses." Staff told us this had not been yet been improved. As a result, staff did not feel fully supported by the provider.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. However they were not aware of the appropriate documentation to use in order to meet the Mental Capacity Act (MCA) requirements.

The registered manager was supported by the operations manager who visited the service on a regular basis. Every month the operation manager reviewed internal audits carried out by the registered manager

that included accidents and incidents, medicines, reviews of people's care plans and updates of documentation, staff vacancies, maintenance issues and complaints. Issues that had been identified at the previous visit were followed up and acted on. When action had not yet been completed, this was reviewed at the next visit and completion dates were set up. The operations manager told us that transitioning all paperwork from the old provider to the present provider's formats and templates was in progress and that staff had encountered difficulties with this task. Senior care workers from a sister home had come to coach the staff but this had not been successful as staff were still unclear about new documentation. The registered manager told us, "We have learned from this and now I sit down with each of the senior care workers and help them through the process."

The provider had commissioned an external consultant to carry out an annual monitoring 'Health check' of the service. This report was comprehensive and based on the Regulated Activities Regulations 2014 of the Health and Social Care Act 2008. Its summary indicated good practice points that had been identified and key recommendations. As a result, out of 17 recommendations, 12 had been implemented and five had been inserted in the registered manager's improvement plan. This improvement plan was updated each week by the registered manager to monitor their progress and contained clear target dates and details of actions that had been taken. The last action plan addressed the management of medicines, scheduled audits of medicines and infection control, staff induction and supervision, training, maintenance, recruitment and wheelchairs checks. However, the monitoring checks that had been carried out had not identified shortfalls in regard to mental capacity assessments documentation. The operation manager and the registered manager told us this will be added to the improvement plan and addressed without delay.

The service's policies were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were kept securely and confidentially. However people's care files were still in process of transitioning to new templates under the new provider and not all had been updated by staff to reflect monthly checks of people's care.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not appropriately carried out when necessary nor recorded as per legal requirements; Best interest meetings were not appropriately carried out when necessary nor recorded as per legal requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to consistently meet people's needs.