M Jalal

Ruksar Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Our inspection took place on 23 August 2016 and was unannounced. At the last inspection in December 2015 the provider was rated requires improvement overall with a breach of regulation 11 in relation to the need for consent. During this inspection we looked to see if improvements had been made. We found the provider was meeting all requirements of the law. We did however identify further improvements were required.

During our last inspection the service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We found the manager had recently made an application for registered manager's status and had been interviewed by our registrations team who confirmed the manager was now awaiting the appropriate certification.

During the last inspection we found the provider was not appropriately displaying the inspection rating. At this inspection we found the provider was complying with this requirement.

Ruksar Nursing Home provides accommodation, personal and nursing care for up to 27 older people. At the time of our inspection there were 26 people living at the location.

People were not protected by robust recruitment practices that ensured care staff were suitable to work in care settings before they commenced work. Some members of staff had started work with recruitment checks incomplete. We found the provider was not meeting all the requirements of the law as they were not completing suitable employment checks to ensure staff were safe to work with people. You can see what action we told the provider to take at the back of the full version of the report."

The risks to people had not been assessed and managed by the provider to ensure only suitable people were employed to work at the home.

People told us they felt safe. We looked at people's care records and saw that people had detailed risk assessments and plans in place to manage risks in order to keep people safe. However, we found inconsistencies in the recording of care and support activities such as repositioning people where the care plan stated this was required to reduce risk. This meant that there was a risk that people were not receiving appropriate care.

People received their medicines safely and as prescribed and were supported to take medicines by staff who were suitably trained and deemed competent. People's medicines were stored safely.

People received care and support from a suitably trained staff team. The registered manager had systems

and processes in place to ensure that staff were kept up to date with their core training. We saw that there were some gaps in staff training, however the registered manager had plans in place to ensure this was delivered.

People were asked for their consent to care and support and the principles of the Mental Capacity Act 2005 were being followed. Staff had a basic understanding of the MCA.

People were supported to have sufficient to eat and drink, however people were not always offered choices of food. People's specific dietary needs were catered for and specialist professional advice in relation to dietary requirements was being followed.

People were supported to access healthcare services when they needed to. People were supported by a staff team who were able to recognise changes in people's health and well-being and knew how to report and respond to any changes.

People were supported by a staff team who mostly showed kindness and compassion. People were supported to make decisions about how their care and support was provided.

People were treated with dignity and respect and their privacy was maintained. People were encouraged to maintain their independence.

People had not always been involved in the planning and review of care, due to their capacity to make decisions. However relatives we spoke with felt they were asked for their opinions and input into their family members care plan. They felt they were kept updated with regards to any changes in relation to their family members care and support needs.

People did not always have access to activities they enjoyed. Planned activities did not always take place as staff did not have the time to facilitate them. Some people we spoke with told us they were able to visit a local park from time to time and people with religious and cultural needs were supported to attend places of worship and practice their religious or cultural beliefs.

People were supported by a staff team who knew people's care and support needs well and had an understanding of people's likes and dislikes.

People and their relatives told us they knew how to raise a concern or complaint and felt confident to speak to staff or the registered manager if they had any concerns about their care. The registered manager had a system for recording complaints and we saw that complaints were investigated appropriately.

People liked living at the home. The registered manager had recently introduced new systems to involve people and their relatives in the development of the service. Staff told us they felt involved in developing the service and felt the registered manager was approachable and acted on their concerns or suggestions.

The registered manager had developed systems and processes to monitor and analyse the quality of the service. We saw they were using information from some of the quality checks to drive improvement; however some systems were not effective in identifying issues or concerns.

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.

People were not always supported by staff who had been recruited safely.
The action taken to keep people safe was not always recorded.
People were supported by adequate numbers of staff.
People felt safe and their relatives told us they had no concerns in relation to safety. People received their medicines safely and as prescribed and medicines were stored safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always given choices at mealtimes and some people had to wait unacceptable periods of time for their meals.
People had sufficient to eat and drink and those who required assistance at mealtimes were provided with appropriate support.
People were supported by a staff team who were suitably trained and had the skills required to support people effectively. People were asked for their consent to care and support and the principles of the Mental capacity Act were being followed.
People had access to healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

People were supported by a staff team who treated them with kindness and respect. People were cared for in a dignified way and their independence was promoted. People were supported to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were not always supported to take part in activities that they enjoyed.

People were supported by a staff team that knew their needs and preferences.
People and their relatives knew how to raise a concern or complaint and were confidents that their concerns would be listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were not always effective at identifying issues or concerns.
Staff were not always recruited safely.
People liked living at the home.
People, relatives and staff were provided with opportunities to give feedback and make suggestions about the development of the service.

Ruksar Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 23 August 2016 and was unannounced. The inspection team consisted of two inspectors, an interpreter and a specialist advisor. The specialist advisor was a nurse who had experience in the care of older people. Through the services of our interpreter we were able to seek the views of those people who spoke Punjabi and Urdu.

Before our inspection, we reviewed the information we held about the service. We reviewed statutory notifications the provider had sent to us since the last inspection. Providers are required to send us notifications to inform us of certain events and incidents, such as serious injuries sustained by people living at the service. We also contacted service commissioners to gather information they held about the service. We considered this information when we planned our inspection.

During the inspection, we spoke with ten people who used the service and three relatives. We also spoke with five care staff, the cook and the registered manager. Throughout the inspection we observed how staff interacted with the people who used the service.

We looked at seven people's care records to see if these records were accurate, up to date and supported what we were told and saw during the inspection. We also looked at four staff records and records relating to the management of the service. These included complaints, accidents and incident records, medicines records and records relating to the management of the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always supported by staff who had been recruited safely. The registered manager and staff told us references and checks with the Disclosure and Barring Service (DBS) were completed for all staff before they started work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people. However, we looked at staff records and found that staff had sometimes started working at the location before suitable pre-employment checks had been completed. We looked at four staff files and found two out of the four staff members had commenced work prior to a DBS check being completed. One staff member had no dates on the references so we couldn't be certain if they had been returned before they commenced work. Two staff members had only one reference check prior to commencing work. This was not in line with the providers recruitment policy. We also found a staff member had unsuitable references which raised concerns about the staff members suitability to work with people. We spoke with the registered manager about this and they told us the staff member had not been dismissed on the grounds that they were unsafe to work with people. However we found no further information on the concerns that led to the disciplinary action and the provider had not completed a risk assessment of the staff member to ensure people's safety. Therefore the provider was unable to demonstrate that they had carried out all of the required checks by law to ensure only suitable people were employed to work at the home. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person we spoke with told us, "I feel happy and safe here, the staff come to me when I call my call bell". Relatives we spoke with told us they felt their family member was safe. One relative told us, "I am confident [person] is safe". People felt safe and relatives had no concerns in relation to their family member's safety.

People's individual care plans contained information about risks and how to keep people safe. For example, falls risk assessments had been completed for people at risk of falls and weight monitoring was being carried out for people at risk of poor nutrition. People who were at risk of choking had the appropriate health professionals involved with their care and staff were following the plans to reduce risks. Risk management plans had been updated as people's needs changed. However, staff had not always followed the instructions to ensure risks were appropriately managed. For example, we looked at people's daily monitoring charts and found staff were not always consistently recording the action they took to protect people from the risk of harm. For example, there were gaps in some people's repositioning charts which meant we could not establish whether people had been turned according to their needs as identified in risk assessments. Staff were able to tell us how people's risks should be managed, however people's daily records did not clearly reflect the requirements of the risk management plans.

People received support from staff who had an understanding of how to protect people from the risk of harm and abuse. Staff were able to tell us how to recognise signs of abuse and how to report it. One staff member said, "I wouldn't see anything bad happen to anyone". Staff were aware of the provider's policies in keeping people safe and told us how they were confident to report and record anything which caused them concern about people's safety. One staff member told us, "I report any concerns about a person's safety to

the nurse in charge or the manager and they take action". For example staff were aware of the providers safeguarding policy. We saw that this had been used and appropriate action had been taken to ensure people were kept safe.
People were supported by sufficient staff to ensure they were safe and their care and support needs were met. One person we spoke with said, "There are enough staff here to care for me". A relative we spoke with said, "There seems to be the same ratio of staff anytime of day, I've never seen that they are short staffed". Staff we spoke with all felt there were sufficient staffing levels to meet the needs of people and ensure their safety. We saw the registered manager used a tool to help them to identify the number of staff required to ensure safe care and support was provided. Staffing levels were based on the needs and dependency of people. The provider had sufficient contingency plans in place to manage staff absence.

People received their medicines as prescribed, however we did see some people's prescribed creams were in the rooms of other people who used the service. This meant that there was a risk of people's prescribed creams being used on other people. People we spoke with told us they received their medicine on time and as prescribed and relatives had no concerns about their family member's administration of medicines. One person said, "There are no problems with my medicines, if I am in pain staff will give me pain relief". Records we looked at confirmed this. People received their medicines from staff who had been suitably trained and had been assessed as being competent to administer medicines. Staff competency was checked regularly and staff records we looked at confirmed this. People's medicines were stored safely for example in a lockable trolley that was stored in a locked room. The medicines storage room was kept at a safe temperature to ensure the efficacy of medicines was not affected. Staff were checking the storage temperatures of medicines. People's medicines were managed appropriately and people received their medicines safely.

Requires Improvement

Is the service effective?

Our findings

At the last inspection which took place on 7 December 2015 we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. It was not clear how staff had assessed or considered if people who used the service were being restricted of their right to freedom. We had concerns about how people's consent to care was obtained and recorded. During this inspection we found the provider was seeking people's consent to care and support and this was appropriately recorded in peoples care records. People told us they were asked for consent before care and support was provided. One person said, "Staff will ask if I want a shower". Staff we spoke with told us they always sought the consent of people before providing support. One staff member said, "We provide care and support when people want it, I ask if they are ready, if they are not I will try again another time". We observed staff asking people if they would like to wear an apron before eating their meals and also asking if they would like them removing after they had finished eating. We observed one person telling a staff member there they would like to keep their apron on after they had finished their meal and this was respected.

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). The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive people of their liberty. At the previous inspection in December 2015 we found the provider was not meeting the regulations regarding people's consent to care and treatment and how decisions were made in people's best interests when they lacked capacity. At this inspection we found the provider had responded to the concerns raised and was now meeting the regulations. During the last inspection staff had limited understanding of MCA. During this inspection we found most staff had received training in MCA and were able to tell us the basic principles of MCA. We saw the provider carried out appropriate assessments of people's capacity. For example, we saw where people lacked capacity; a capacity assessment had been completed and detailed the specific decisions that people were not able to make for themselves. Where decisions needed to be made in people's best interests, we saw best interest meetings were held. The registered manager had been in contact with the local authority to take advice on whether DoLs applications were required for particular people. The registered manager had a good understanding of MCA and DoLS and staff were able to tell us when a person's liberty might be being restricted and who they would report this to.

People were supported by a staff team who received sufficient training to effectively support people with their care and support needs. People and their relatives told us they felt the staff were appropriately trained to carry out their roles. One relative said, "From the way they lift [person] with the hoist, they seem to know what they are doing". Staff told us they had regular training. One staff member told us how they had requested a refresher course and had recently completed a course on diabetes. The registered manager had systems in place to ensure people were kept up to date with training. We found some gaps in staff training,

however we spoke to the registered manager about this and they told us staff had been booked on training and this would take place within the next few weeks. This would mean that all staff would be up to date with core training. Staff told us they had regular one to one sessions with the registered manager where they were able to discuss their practice, raise concerns or ideas and discuss training needs. Staff records we looked at confirmed this.

People were supported to have sufficient to eat and drink. One relative told us their family member was refusing to eat, and staff had given them nutritional supplements. During the inspection we observed people being asked frequently if they would like a choice of hot or cold drinks and we saw jugs of juice in the lounge areas for people to help themselves. However, we found people were not always offered a choice of food. Some people told us they were asked what they wanted to eat whilst others told us they were not provided with a choice. For example, one person said, "Staff give me a choice at mealtimes, they ask what my preferences are and take them into account". Another person we spoke with told us, "Staff don't ask if I want a choice, but it is ok". A third person said, "We just eat whatever is given to us". We observed a fourth person being given a meal, We spoke with the person who told us they did not know what they were having for their lunchtime meal and had not been told what it was when it was given to them. We spoke with the cook who told us there were daily menu plans, however during this inspection we observed lunchtime and we saw the food provided did not reflect what was on the menu for the day. We spoke with the cook who told us they had developed a pictorial choice card system to assist people to make choices about their food where they had difficulty communicating verbally. However we did not see this being used during the inspection.

Mealtimes may not have been a pleasant experience for all people. We observed some people having to wait lengthy periods of time for their meals. For example, one person had to wait an hour after other people were served their meals before their meal was served. We asked a member of staff if there was a reason why the person's food was so late to establish if this was the person's preferred time to eat lunch, however the staff member we spoke with said they did not know why the person's meal was so late and advised us that the person did not have a preferred later meal time. We saw five people waiting for 10 minutes before getting their meals whilst other people were being served their lunches. We saw one person become quite agitated at this and started to try and eat another person's food. We observed two other people waited for thirty minutes before their lunch was served. People had to wait unacceptable periods of time for meals.

People who required support to eat and drink were supported appropriately. We observed people being supported to eat at a pace they were comfortable with. Staff asked people if they were ready for some more food before offering a spoonful to the person. People's specific dietary requirements or cultural or religious food preferences were catered for. For example, we saw people having a softened or pureed diet as recommended and people could request halal food if required. People received appropriate support to eat and drink and specialist diets were catered for.

People were supported to maintain their health. One person we spoke with told us, "I have been to see the doctor and sometimes they come here to see me, the dentist comes here and the optician". We saw that people had access to a range of health professionals such as, GP's, opticians, dieticians, speech and language therapists, dentists and occupational therapists. We saw evidence of people's healthcare appointments recorded in care plans and any actions to be taken were completed. People who were living with diabetes had regular blood sugar level tests and we saw evidence of these readings being sent to the GP. Staff knew how to report any changes or deterioration to people's health or well- being. One staff member told us, "People have good access to healthcare, any changes to a person's health is reported to a senior who will take the appropriate actions such as calling a GP or the emergency services". People had access to a variety of health professionals when they needed them and were supported by staff who knew how to identify and respond to a change in people's health needs.

The home had a number of people living there who lived with dementia. We found the premises required some work to ensure that the environment was made dementia friendly. For example, there was no signage on people's bedroom doors to help them to establish which bedroom belonged to them. There were no contrasting colours in the corridors or signposting for people to be able to orientate themselves, for example to the toilets. Such adaptations would better assist people living with dementia to navigate around the building. The provider was currently in the process of refurbishing the building and the registered manager told us they would discuss the possibility of adapting the building to make it more dementia friendly.

Good

Is the service caring?

Our findings

People told us they were supported by staff who were kind and caring. One person we spoke with told us, "The staff are excellent, they are always caring, they treat you like their own relative". Relatives we spoke with felt their family members were being well cared for. One relative said, "I can't fault what the staff do, nothing is too much trouble for them". They went on to tell us, "Staff are caring, very approachable and so accommodating". A member of staff told us, "I like to help people, I enjoy helping them". During the inspection we observed some positive caring interactions between people and staff and we saw that staff took the time to talk with people whilst carrying out care and support. For example, we observed carers asking people if they were ok and if they needed anything throughout the day. We also observed staff checking people were enjoying their meals. However we did observe times where there were missed opportunities for staff to engage in conversations with people. For example, some staff did not engage in conversations with people whilst supporting them to eat and drink. We spoke to the registered manager about this and they told us they would look into this issue.

People told us they were offered choices about how their care and support was delivered. For example people told us they were offered choices about what time they got up in the morning and when they went to bed. They also told us they were offered choices regarding what clothes they wore and whether they preferred a wash, bath or shower. One person we spoke with said, "This morning they asked me if I would like a bath and then after they asked me what I would like to wear". One staff member we spoke with said, "People are given choices such as what they want to eat and drink, whether they want a hot or cold drink, what time they get up in the morning and what time they go to bed". People were provided with choice and control over their care and support.

People received information in a way they could understand, which helped them to make clear choices about their care. For example a number of people used English as a second language. We observed staff speaking to people in their preferred language. Staff told us the registered manager always ensured there was a staff member who could communicate with people in their preferred language on shift at all times. The registered manager said, "I make sure there is always a member of staff that can speak Punjabi allocated to each shift". Staff also told us how they adapted communication techniques to enable people to communicate their choices or preferences. For example by using basic sign language or non-verbal gestures. This meant people were able to express their wishes as they were supported to communicate in a way in which they preferred.

People were supported and cared for by a staff team that treated each person with dignity and respect. One person told us, "Staff are respectful, they treat me with dignity and respect". One relative we spoke with told us how their family member enjoyed a glass of wine occasionally and how staff were respectful of the persons choice to have an occasional alcoholic drink. Staff we spoke with told us about ways in which they maintained and promoted people's privacy and dignity such as closing doors and drawing curtains during personal care and knocking on a person's bedroom door before entering their bedroom.

People were encouraged to be independent. One relative we spoke with told us how their family member

was cared for in bed but was encouraged to do what they could for themselves, Staff we spoke with told us how they encouraged people to do what they could for themselves. We looked at people's care records and saw that the provider was supporting people to live independent lives by requesting equipment to help people to mobilise independently where possible. For example, we found one person had been referred to an occupational therapist for walking aids to help them to mobilise independently.

People were supported to maintain relationships that were important to them. The registered manager told us there was no restriction on visiting times and we saw relatives visiting throughout the day.

Requires Improvement

Is the service responsive?

Our findings

People did not always have the opportunity to engage in activities which they enjoyed or follow personal interests. One person said, "I just sit in the chair all day, I can't go out because I haven't got the money". Another person said, "I go to the mosque, but there are no other activities, I just sit in my chair". A relative we spoke with said, "I visit most days and I haven't seen any activities". One staff member said, "We could do with an activities co-ordinator so that there is more time to deliver activities". We spoke with the registered manager about this who told us, "We don't always have the time to deliver activities". They told us people were encouraged to read or were taken out to the park when possible and they would look into providing more activities for people to engage in and look to increase opportunities to support people to follow their interests. People's cultural and religious beliefs were taken into account. For example people were supported to attend places of worship. One person told us, "Staff got me up at 7am well in advance, got me bathed and dressed in my suit and took me to the temple".

People were supported by a staff team who knew their needs and preferences well. Staff were able to tell us about people's care and support needs and how they liked their care delivered. One person said, "Staff know exactly what medicines I need and what my medical conditions are". Another person said, "The staff know how to look after me". A relative we spoke with told us, "The staff know [person] well". The registered manager told us, "We ask people and their relatives what they like to do, what their likes and dislikes are". We saw records relating to how people preferred their care and support to be delivered. For example, how people preferred to take their medicine. People's requests for help and support were responded to promptly. We observed a person trying to communicate to staff that they wanted their drink putting in a cup rather than a beaker and staff responded to their request promptly. The registered manager had internal communication systems in place to enable staff to effectively share information relating to the people living at the location. For example a daily handover meeting was held to provide information about people's changing care and support needs. Staff told us they were regularly kept up to date with people's changing needs and were informed of people's care and support needs and preferences on admission to the home. We looked at people's records and saw that where there was a change in people care and support needs these were recorded.

People were involved in the planning and review of their care where possible and relatives we spoke with felt they were able to contribute to their family members care plan. One relative we spoke with told us, "I can't fault them, they keep me informed and let me know what's going on". They went on to tell us, "I met the registered manager they went through all of [persons] likes, dislikes, history etc. There have been two reviews recently". Another relative said, "Staff talk to me about [persons care], I can have a say in their care".

During the last inspection people and their relatives were not always aware of the provider's complaints procedure. During this inspection, we found most people and their relatives who we spoke with knew how to raise a concern or a complaint. One person said, "I've never had to complain but I feel if I had a concern staff would listen to me". A relative told us, "I know how to raise a complaint, I have never had to". We looked at records relating to complaints and found complaints had been logged and actions taken to address concerns were recorded.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection we rated the service as requires improvement for well led. The reason for the rating was that the provider did not have a registered manager in post and the last rating certificate had not been displayed as required by law. During this inspection we saw improvements had been made. The provider had a manager in post who had recently been interviewed for the registered manager role and was awaiting their certificate to be issued. We found the rating certificate was appropriately displayed. We did however identify further improvements were required.

The provider had systems in place to monitor the quality of the service. Internal checks were carried out and we saw information from some of these quality checks was used to drive improvement. For example, we saw regular medicines checks were completed, where errors had occurred we found the registered manager had taken appropriate action to address the issues. We saw information from accidents and incidents was analysed and used to inform peoples risk assessments and to make positive changes. For example we saw analysis of falls carried out in February this year had identified the need for staff to be present more in communal areas. During this inspection we saw this was in place. However the providers quality assurance systems had failed to identify concerns relating to the safe recruitment of staff. During this inspection we found the provider was not always using safe recruitment practices. This meant that people were at risk of being supported by staff who were not suitable to work with people. We also found there had been some recent developments in relation to gathering people's feedback about the service. The registered manager had recently conducted a survey to ascertain people's satisfaction with the quality of the care and support they were receiving. However the survey had not been effective at identifying the some of the specific needs or concerns of the people living at the home. For example, the survey had not identified the lack of opportunities people had to engage in activities or follow personal interests or hobbies. Whilst some of the systems to monitor the quality of the service were effective and used to drive improvements we found that the systems were not always effective in identifying and addressing issues or concerns.

People told us they liked living at the home. One person said, "I am happy here". One relative told us they were planning to move their family member to another home so they could be closer to them, however their family member liked the home so much they did not want to move and as such would be staying there. Another relative told us they would recommend the home to others.

Staff felt involved in the development of the service. One staff member told us they had completed a staff survey. Staff told us they felt the registered manager was approachable, listened to their concerns and acted on them. One staff member told us, "The registered manager is very approachable, they listen to you and take you seriously". We spoke with the registered manager who told us how they had responded to staff feedback regarding staffing levels. They had increased staffing levels in the afternoon, employed a maintenance person and a kitchen assistant. They told us, "Staff have not made any further complaints since I increased the levels of staff".

Staff felt supported by the registered manager. One staff member told us, "I feel very supported, if you have any problems you can always talk to the registered manager". They went on to tell us, "The registered

manager is very approachable, they listen to you and take you seriously". Staff also told us the registered manager was a visible presence in the home and took a practical 'hands on' approach to support staff if required. One staff member said, "The registered manager is a visible presence, they go and check residents are ok in the mornings". The registered manager told us, "I help out on the floor, for example, at lunchtimes if I can".

The registered manager understood their roles and responsibilities. They were aware of which events needed to be notified to us, such as serious incidents, and we saw they were doing this appropriately. The registered manager told us they kept up to date with current best practice and legislation by attending training events. They said, "I recently attended MCA and DoLS training through a local hospice facility".

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Provider was not always using safe recruitment practices to ensure staff were of a suitable character to work with people.