Care Quality Commission

SSL Healthcare Ltd

Brookfield Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 15 December 2015 and was unannounced. This meant that the provider did not know we would be visiting. A second day of inspection took place on 16 December, and was announced. The service was previously inspected on 12 May 2014 and was meeting the regulations we inspected.

Brookfield Care Home can accommodate up to 30 people. The home is situated in the village of Lazenby which is close to the coastal town of Redcar. The home has two units. The ground floor accommodates people living with a dementia. The first floor accommodates people requiring personal care. There are enclosed gardens which people who used the service can use. At the time of the inspection 27 people were using the service, 19 of whom were living with dementia.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Care plans were not always responsive for people who had complex and specific mental health conditions. People did not have access to a wide range of activities, which meant that they could be at risk of social isolation. This prevented them from maintaining relationships and links with their community. These were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

The building was clean and appropriately maintained. However, items were inappropriately stored in communal areas and cupboards in a potentially hazardous way. This also meant that some areas did not look homely for people living at the service.

Risks to people using the service were assessed and care plans were designed to minimise them. Risks arising from the premises were also monitored and addressed. Staff understood safeguarding issues, and the service operated procedures to deal with any incidents that occurred.

The service had policies and procedures in place to ensure that medicines were handled safely. Accurate records were kept to show when medicines had been administered. Some information was missing from people's medicine identification records, but we told the staff about this and it was remedied during the inspection.

People were supported by staff who had been appropriately recruited and inducted as pre-employment checks were carried out.

Staff received suitable training to ensure that they could appropriately support people. Staff said they received sufficient training to do their jobs, and felt confident to raise any professional development needs at their regular supervisions and appraisals.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people received care that they consented to or was in their best interests.

People received suitable support with food and nutrition and were able to maintain a balanced diet. Mealtimes were enjoyable for people using the service, and they were offered drinks and snacks throughout the day.

The service worked with external professionals to support and maintain people's health. The professionals we spoke with had no concerns about the service.

Staff treated people with dignity, respect and kindness and were knowledgeable about people's needs, likes, interests and preferences. People had access to advocacy services.

Care plans for people without complex and specific mental health conditions were person-centred and reflected the care and support that they wanted. People's preferences and needs were reflected in the support they received.

The service had a clear complaints policy, but this was not always applied when issues were raised informally.

The registered manager used audits to monitor and improve standards. Staff felt supported and included in the service by the registered manager and the provider. People and their relatives were invited to meetings to give feedback, but attendance was low and there was no other formal system for asking people what they thought of the service. The registered manager said they felt supported by the provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

The building was clean and appropriately maintained. However, items were inappropriately stored in communal areas and cupboards.

Risks to people using the service were assessed and care plans were designed to minimise them, including any risks arising from the premises.

People were supported to access their medicines safely.

The service operated robust recruitment procedures to ensure that only suitable staff were employed.

Good

Is the service effective?
The service was effective.

Staff received suitable training to ensure that they could appropriately support people, and received supervisions and appraisals.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards to ensure that people received care that they consented to or was in their best interests.

People received suitable support with food and nutrition and were able to maintain a balanced diet.

The service worked with external professionals to support and maintain people's health.

Good

Is the service caring?
The service was caring.

People were treated with dignity and respect.

Care and support were delivered with kindness and staff knew people well.

People had access to advocacy services.

Good

Is the service responsive?
The service was not always responsive.

Care plans were not always responsive for people who had complex and specific mental health conditions.

People did not have access to a wide range of activities, which meant that they could be at risk of social isolation.

The service had a complaints policy, but this was not always applied when issues were raised informally.

Requires improvement

Summary of findings

Is the service well-led?	Good
The service was not always well-led. The registered manager used audits to monitor and improve standards. Meetings for people and relatives to give feedback were held but attendance was low. There was no other formal system in place for obtaining their feedback. Staff felt supported and included in the service by the registered manager and the provider. The registered manager said they felt supported by the provider.	

Care Quality Commission

Brookfield Care 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.

This inspection took place on 15 December 2015 and was unannounced. This meant that the provider did not know we would be visiting. A second day of inspection took place on 16 December, and was announced

The inspection team consisted of two adult social care inspectors and a specialist advisor.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider completed a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with three people who lived at the service and three relatives. We looked at five care plans, and Medicine Administration Records (MARs) and handover sheets. We spoke with 11 members of staff, including the registered manager, the deputy manager, a senior carer, five care assistants and members of the domestic, kitchen staff and maintenance. We also spoke with one external professional who works with the service.

We also completed observations around the service, in communal areas and in people's rooms with their permission. We also carried out an observation using the SOFI framework. This is a method that helps us to observe how care is delivered to people who have difficulty in communicating with us.

Good

Is the service safe?

Our findings

The building was clean and looked well maintained. However, we noted that some items were inappropriately stored in communal areas and bathrooms. This meant that the service did not always look homely or welcoming. For example, a laundry hopper was stored in a bathroom on the first floor. In another bathroom we saw that aprons were stored on a bath seat. In a cupboard underneath the stairs continence pads were stored next to a mop standing in a bucket of dirty water. There were a number of items stored in a stairwell, for example wheelchairs, electric fans, empty Christmas decoration boxes and black bin liners. We asked the registered manager about storage at the service. They said, "We have a shed on order."

Staff at the service carried out a number of risk assessments to help keep people safe. People were assessed for risks in areas such as falls, mobility, hoisting, pressure damage, skin integrity and nutrition. Assessments were reviewed on a monthly basis to ensure that any new risks were identified. The results of these assessments were used to develop people's care plans. Where changes occurred, new risk assessments were put in place and care plans were updated. For example, we saw that one person had a fall in October 2015. This led to a risk assessment of hoisting and standing transfers, and the care plan was updated to reflect the fact that the person would need more help in the weeks after the accident due to a lack of confidence. This meant that risks to people's general health were assessed and plans were put in place to minimise them.

Safety checks of the building and equipment were regularly undertaken. The registered manager said, "I do a full workaround every shift I am on and check health and safety." A member of the maintenance staff said, "I do checks of alarms, nursing call and emergency lights and we have [an external company] come in for a yearly service." Records confirmed that monthly checks of fire alarms, emergency call systems, water temperatures, beds and hoists and emergency lights were undertaken. We noted that the last annual audit of the premises by the external contractor had taken place in April 2014. When we asked the registered manager about this they said they would arrange for the audit to take place the following week. They told us this had been arranged on the second day of the inspection. The service had a procedure in place for recording and monitoring accidents. The deputy manager said, "Staff fill in an accident form which goes into the person's care plan. They also make a monthly audit sheet for me to look at. I make sure it corresponds with the accident book and if there are any gaps in the accident report I will send it back…to be updated." The deputy manager also said that they looked for trends in accidents in order to take any required remedial action. This meant that procedures were in place to ensure that premises and equipment were safe for people to use.

People's medicines were managed safely. We looked at 27 medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. There were no omissions in administration or recording, which meant that it was easy to see when people had received their medicines. Where medicines were administered covertly this was done appropriately and letters of authorisation were included in the MAR file. Covert administration is where medicines are administered to people without them knowing. However, we did see that some people's MARs did not record all of their allergies or contain their photographs. We discussed this with staff. The photographs were added at the time of the inspection and we were told that the allergies would also be updated. The treatment room was neat and tidy and the medication fridge was in working order, with the temperature checked on a daily basis. A stock check was undertaken every week and a monthly audit of MARs and medication was carried out every month by the registered manager. The controlled drugs cabinet was appropriately attached to the wall within a locked medicine cabinet and a clear record was kept of controlled drug stocks. Controlled drugs are medicines that are liable to abuse. We observed the lunch time medication round which was carried out professionally and competently and in a sensitive manner with staff always identifying themselves and checking consent with the person before carrying out the administration. This meant that people were supported to access their medicines safely.

Staff were aware of safeguarding policies and procedures. The safeguarding policy contained definitions of the different types of abuse that might arise, signs to look out for and the procedure to be followed when reporting concerns. Where incidents occurred we saw that reports contained details on what had happened, actions taken in response and any external referrals made. For example, we

Good

Is the service safe?

saw that one incident led to a referral to the falls team. The deputy manager reviewed safeguarding incidents on a monthly basis and submitted a monthly log to the local authority safeguarding team to keep them informed of any issues arising. Staff received training in safeguarding and had a good working knowledge of safeguarding issues. One said, "I have done safeguarding training. We look for physical, mental, financial abuse of people. I'd raise it with the manager and they'd know what to do." Another said, "I've done safeguarding training and there is a policy in the office." A visiting professional we spoke with did not raise any concerns in relation to safeguarding. This meant that procedures were in place to minimise the risk of safeguarding incidents occurring.

The service had plans in place to provide care and support in emergency situations. Each person had a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEPs were stored in a convenient place next to the front door, for easy access in an emergency situation. Each PEEP contained information on the person's mobility and support needs, and the assistance they would need in an emergency. The PEEPS were regularly reviewed, and had been updated in December 2015. There was a business continuity plan in place dated June 2015. This contained guidance to staff on dealing with a number of emergency situations, including useful contact details. Arrangements had been made with a nearby home to provide continuity of care and emergency accommodation. This meant plans were in place to provide a continuity of care for people in emergency situations.

Staffing levels were monitored to ensure there were enough employed to support people safely. A 'dependency level review' tool was used to determine safe staffing levels, and the deputy manager reviewed this on a monthly basis or if a change occurred such as a person being admitted to hospital. Day staffing (during the week and at weekends) levels were one team leader, two senior carers, a carer and an apprentice) working from 8am to 9pm. There was an additional shift worked by one carer between 12.30pm and 5pm. Night staffing levels (during the week and at weekends) were one senior carer and two carers working from 9pm to 8am. Staff rotas confirmed this. We asked staff about staffing levels. One said, "I think there are enough staff. I always feel that there are. If someone is off sick they phone around and it always gets covered." Another said, "I think there are enough staff to look after people." A visiting relative told us, "I think there are enough staff." A visiting external professional said, "It doesn't seem disorganised or chaotic so I don't think they're understaffed." This meant there were enough staff to support people safely.

Recruitment checks and procedures helped to ensure that only suitable staff were employed. Application forms asked people about their employment and care experience, and interview notes confirmed that applicants were asked about their care skills and how they would deal with difficult situations. References were sought, including – where possible – from previous employers. Disclosure and Barring Service checks were carried out before people started work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. A member of staff said, "When I joined I had to do a DBS check, bring in two pieces of ID, certificates and then I was interviewed. I also had to have two references." This meant the service minimised the risk of employing unsuitable staff.

Good

Is the service effective?

Our findings

Staff received the training they needed to support people effectively. Mandatory training was given in areas such as safeguarding, manual handling, first aid, fire safety and infection control. Mandatory training is training that the provider thinks is necessary to support people safely. Refresher training was provided, and we saw from training records that it had been delivered in line with deadlines set by the service. Some staff were undertaking NVQs in Health and Social Care at levels 3 and 5. New staff completed an induction programme, which consisted of an introduction to policies and procedures and the people using the service, shadowing staff and being supervised delivering support. Staff said that they received the training the needed to carry out their roles. One said, "I did the induction training with [the registered manager]. We covered things like moving and handling and first aid. It was enough to start the job and I have had training since in things like first aid, health and safety and the Mental Capacity Act." Another said, "The training is very good." A visiting external professional thought that staff had the skills and training they needed. They said, "They always come in with hoists and things like that. They have people here who are living with dementia and the way they are cared for is just lovely."

Staff were supported in their roles through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff received six supervisions a year and an annual appraisal, and records showed that this was happening. Minutes of supervisions and appraisals showed that staff performance was reviewed and training and personal development was discussed. Supervisions were also used to remind staff about topics such as continence care, housekeeping, safety and documentation. One member of staff said, "I think supervisions and appraisals are quite good as there is one to one time to discuss things. We can request extra training. I once requested end of life care training and got it." This meant that staff were given guidance and support through supervisions and appraisals.

People were supported to maintain a healthy diet. Where people were assessed as being at risk of malnutrition care plans were in place, supplements prescribed and food and fluid balance charts recorded. Staff we spoke with at lunchtime were able to describe if people were on any specialist diets such as soft foods or supplements and we saw that people received these. Most people chose to eat in the dining room, though some people ate in their rooms. We saw that those people received their food in a timely manner and were not left waiting. There was no menu on display, but the cook said that usually there would be but it was in the process of changing and had not yet been rewritten. People were given a choice between two meals and spoke positively about the food. One said, "The food is very good here." Another said, "It's always nice and there's plenty of it. There's always a choice." A visiting relative said, "The food is good." People were also offered drinks and snacks throughout the day. This meant that people were effectively supported with food and nutrition.

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).

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. 19 people were subject to DoLS at the time of the inspection. Care plans contained records of DoLS applications and references to best interest decisions and capacity assessments. A record was kept of when people's DoLS expired so that staff could, if needed, make further applications. Where relevant, care plans contained evidence of people's Lasting Power of Attorney and what it related to. Staff were able to describe the principles of the MCA and how they applied them when supporting people. One said, "The MCA is there to protect people. For example, if someone was living with dementia and wanted to go out it may be that it is in their best interest not to go alone for their safety so we would go with them…You can never make assumptions about capacity and must always go through the proper channels." Staff told us how they obtained consent from people who had mental capacity.

Good

Is the service effective?

One said, “We would always give people a choice. You never presume.” This meant that people’s rights were protected and that care and support was delivered with consent.

People were supported to access external services to maintain and promote their health and wellbeing. Care plans contained evidence that health and social care professionals were involved in the care of the people. For example, one person’s ‘medical services log’ showed that they were seen by the community practice nurse at the request of staff. The service engages with ten different G.P. practices and is in regular contact with them as and when needed. The deputy manager said that from January 2016 there will be a programme of regular six monthly reviews put in place. Throughout the inspection we saw staff telephoning services such as the blood clinic or GP surgery to chase test results or appointments. A visiting district nurse said that the service “Is one of my favourite homes to visit…the staff are always friendly and welcoming and receptive to advice I give, especially in relation to wound care... staff always takes an interest in the care I give and are willing to learn new skills, I would say we have a very good working relationship.” This meant that people’s health and wellbeing was promoted by the service working effectively with external professionals.

Good

Is the service caring?

Our findings

A visiting relative said of the service, “I think it is good. It has caring staff.” A visiting external professional said, “I think this place is amazing. The staff are always friendly…it is a really nice home.”

People were treated with dignity and respect. Throughout the inspection we saw staff behaving professionally in a helpful, knowledgeable and sensitive manner. Staff treated people with dignity and respect by knocking on doors before entering, addressing people by their preferred name and explaining what support they were about to carry out and why, such as in the administration of medication or positional changes in bed. In another example, we saw a person being hoisted from their chair. Staff took the time to explain what they intended to do before starting, asked for permission to do it and explained what was happening at every stage of the move. Where people requested support, staff approached them and asked them how they could help in a discreet and respectful way. We saw one person who was living with dementia become confused as to why they did not have to pay a visiting hairdresser. Staff took time to explain to the person that the hairdresser had already been paid. The person was reassured and clearly enjoyed the rest of their time with the hairdresser.

We asked staff how they treated people with dignity and respect. One said, “We always make sure we’re talking to people in the right way. I would want people to feel I was taking over. I always make sure we keep things private for them.” Another said that when they delivered personal care they, “Put a towel around people and explain what we’re doing. I give people a choice to try and keep them independent, for example some people we can just prompt and give them their face cloth.”

Throughout the inspection we saw staff delivering care and support with kindness. Staff took the time to talk to people as they moved around the building, which people clearly enjoyed. Staff obviously knew the people they were supporting well and were able to discuss their families and interests with them, ranging from what relatives were up to that week through to their favourite programme being on television that day. Staff were alert to people’s needs, and quickly intervened when they arose. For example, we saw one person who was living with dementia and engaged in doll therapy. Doll therapy is used to communicate with and reassure people living with dementia. The person mislaid their doll, and we saw staff quickly intervene and offer reassurance in a kind and sensitive way. The person clearly appreciated this, and walked away looking happy and relaxed. Staff used appropriate touches to reassure people who looked upset or distressed, and we saw that this comforted people.

There was a homely atmosphere in the communal areas of the service, and most people chose to spend time in the lounge. We observed that people were excited in the run up to Christmas, and staff were discussing people’s plans with them and ensuring that everyone felt included.

At the time of the inspection one person was using an advocate. Advocates help to ensure that people’s views and preferences are heard. The registered manager said, “We used to have another person who used one. If someone needed one we would go through their social worker. Sometimes if a person has a capacity assessment the best interests assessor will also arrange one.” This meant the procedures were in place to support people to access advocacy services where appropriate.

Requires improvement

Is the service responsive?

Our findings

People had access to activities, but it was not always clear whether these were based on people's assessed preferences. There was no activity planner or schedule for people to see that was happening at the service, and when we asked people they could not tell us what activities were taking place. One person said, "I don't know if we do activities. Do we do activities?" Another said, "We did a ball game once." We were shown attendance sheets that were completed after activities, showing who had participated. In December 2015, activities included games afternoons, 'nails', Christmas decoration making and 'films.' The attendances logged ranged between three and twelve people, and feedback was not recorded. There was a carol performance by children from a nearby primary school during the inspection, which 17 people attended. The registered manager told us that the service had good links with the school, and that children had attended a special performance of a pantomime organised by the home. We asked staff about activities. One said, "I think there are plenty of activities but some people are reluctant to join in. It's down to staff to try and fit activities in. The [extra] shift has helped as they often do activities." Another said, "We have a [an extra] shift for activities but sometimes people don't want to do them." It was not clear how the service was seeking feedback on people's activities preferences and using this to plan activities that they would enjoy and want to take part in. Our judgment was that people were at risk of being socially isolated due to the lack of activities suitably tailored to their specific needs and interests.

This was a breach of Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were not always responsive for people who had complex and specific mental health conditions. For example, the pre-admission assessments for a person who had a history of mental health conditions stated only that the person had 'depression and anxiety' and there was no specific detail to help formulate appropriate care plans or provide key information to staff. Where people were living with dementia, care plans were sometimes basic and not always specific enough for the condition. For example, the care plan for a person living with Lewy body dementia did not contain specific information on their individual symptoms and how staff could manage them. People had documented involvement with specialist services such as community psychiatric nurses and psychiatrists, and our judgment was that people were receiving responsive care but that care plans did not always reflect this.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans for people without complex and specific mental health conditions were person-centred and reflected the care and support that they wanted. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans began with a summary sheet with a photograph of the person, what was important to them and how they could best be supported. Care records included care plans in areas such as personal care and wellbeing, diet and weight, mobility, continence and family involvement. These were reviewed on a monthly basis to ensure that they reflected people's current needs. Plans included details of things that people felt were important. For example, one person's plan said that they liked to have their hair combed as they "like to take care of [my] appearance." Throughout the inspection we saw staff helping the person to comb their hair. This meant that general care plans reflected people's personal preferences.

Procedures were in place to investigate complaints. A complaints policy - covering both oral and written complaints - set out how issues would be investigated and the timeframes for doing so. The policy was contained in the resident guide that was given to people when they joined the service, but was not publically displayed when we began the inspection. We noted that it was displayed in communal areas by the end of the first day of the inspection. There had been no formal complaints received within the last 12 months however the registered manager described a complaint that had been made by a family member which had not been put in writing or taken any further. Although this was not made as a formal complaint the policy states that even a 'grumble' or a negative comment should be noted as not all complaints had to be formal to be acted on. There had been no record made of the incident described to us. The registered manager said that in future the policy would be applied to all complaints.

Good

Is the service well-led?

Our findings

Records confirmed that meetings were held with people and relatives. Signs were displayed around the service advertising these, but the registered manager said that attendance was not high. We saw from minutes of a meeting held on 6 October 2015 that three people (excluding staff) attended, and that issues discussed included storage of items in communal areas and the condition of some furniture. We asked the registered manager how else they obtained people's feedback given the low attendance at meetings. They said, "[Meetings] aren't that well attended. We have one or two people come, and one relative. There are no other questionnaires on feedback. It is more verbal. We always ask people how they're getting on. Maybe we should record it. I like to keep an eye on things." A visiting relative said, "If I had any issues I would speak to the registered manager or deputy manager about it. Their door is always open."

We asked staff to describe the culture and values of the service. One said, "It's a really vibrant, bubbly environment where people can feel safe and secure." Another said, "It's a lovely, homely place."

The registered manager carried out a number of checks and audits to maintain and improve the quality of the service. These included monthly checks of medicines, daily health and safety checks and a daily 'manager's checklist.' This covered areas such as checking the staff handover between shifts, any issues logged in the daily communication book, the accident and complaints logs and a sample of care plans. The registered manager said, "I always come in half an hour early so I can have some quality time with night staff and I take the handover." A more detailed review of all audits undertaken took place every month. This included reviewing people's risk assessments and care plans, staffing levels and maintenance certificates. This was last done in November 2015. This meant that systems were in place to monitor and improve the quality of the service.

Staff felt supported by the registered manager and the provider. One said, "[The provider] always asks if we need anything, and we see them him 2-3 times a week. They will sometimes just come in for a chat. [The registered manager] is very supporting and a great colleague. [The provider] will sort out any problems and [the registered manager] has taught me a lot." Another said, "I feel valued here. You can go to management with anything."

Staff told us that staff meetings took place, and records confirmed this. Minutes from meetings showed that they were used to discuss a number of different policies and issues relating to the running of the service. For example, at a meeting on 17 April 2015 staff were updated on staff changes and reminded of the importance of record keeping and infection control. Staff told us that

they were free to raise issues at staff meetings, or at any time outside of meetings.

The registered manager felt supported by the provider in managing the service. They said, "The provider is going to start doing supervisions with me. If I need training I speak to professionals. I have a very good relationship with [a district nurse]. Yesterday, I arranged training for myself on Lewy body dementia with them. I have communication with the other registered manager in the group and will pop in for a cup of tea or speak on the phone if I need advice. If either of us has spare training places on our courses, we will offer them out to each other." The registered manager understood their responsibilities. We noted that all relevant notifications concerning the service had been made to the Commission.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not supported to maintain relationships or involvement in their community due to a lack of activities provision. Regulation 10(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Care plans were not always responsive for people who had complex and specific mental health conditions. Regulation 17(2)(c).