Care Quality Commission

Casterbridge Homes Limited

Deanwood Lodge

Inspection report

Church Road
Maisemore
Gloucestershire
GL2 8HB

Tel: 01452415057

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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

We inspected Deanwood on the 6 January 2016. Deanwood Lodge provides residential and nursing care for older people; many of the people living at the home had a diagnosis of dementia. The home offers a service for up to 47 people. At the time of our visit 34 people were using the service. This was an unannounced inspection.

We last inspected in March 2015 and found the provider was meeting all of the requirements of the regulations at that time.

There was not a registered manager in post on the day of our inspection. The previous registered manager had left in November 2015. A new manager had been appointed and they were in the process of applying to become the registered manager. 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.

People told us there were not always things to do and that life in the home could be boring. Some people went periods of time without any contact with care staff. There was an activity co-ordinator in post who was due to leave the service, however another two activity co-ordinator was due to start at the home shortly.

People were not always protected from the risks associated with their care. One person had a choking incident as they had been given food which was not in accordance with their assessed needs.

The provider had not ensured that systems were in place and regularly undertaken to sufficiently assess, monitor and continually improve the quality and safety of the services provided, including the quality of the experience of service users in receiving those services.

People were not always protected from the risks of environment or in the event of a fire. Fire safety and maintenance checks were not being carried out in accordance with the provider's policies. Some rooms which contained items that could put people at risk were not always secured.

Care staff treated people with dignity and respect when they assisted them with personal care and mobility. However, they did not always ensure people's drinks were left close to them to enable them to assist themselves independently. Care staff sometimes made choices for people over what they would like to eat or drink, without giving them choice.

People received their medicines as prescribed. Care staff did not always keep an accurate record of the support they have given people with their medicines. Where people needed their medicines covertly, care staff followed clear guidance to ensure their needs were met.

Care staff ensured where people needed assistance with their personal hygiene that they were kept clean and comfortable. Staff showed genuine care for people if they were anxious or unhappy.

People were supported by kind, caring and compassionate care staff. Staff spoke positively about people in the home and knew what was important to them.

People told us they felt safe in the home. Staff had a good understanding of safeguarding and the service took appropriate action to deal with any concerns or allegations of abuse.

People's needs were assessed. Where any risks were identified, management plans were in place. People's care plans were being updated by staff at the home.

People's relatives spoke positively about the manager. The manager had clear aims to improve the quality of service people received in the home. A new clinical lead had been appointed and the provider had implemented an action plan with an aim to ensure people received a good service.

Care staff had access to development opportunities to improve their skills and the service people received. Care staff received the training they required to support people with individual needs and had access to effective supervision (one to one meetings with their manager).

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People could not be assured they would be safe in the event of a fire. There was a potential risk to people living in the home as safety checks were not carried out regularly.

People received their medicines as prescribed, however staff did not always document the support they provided people and did not always keep an accurate record people's medicine stocks.

Staff understood their responsibilities to report any concerns to the manager. There were enough staff deployed to meet the personal care needs of people at the home.

Is the service effective?

Requires Improvement

The service was not always effective. People were often supported to make day to day decisions around their care. However people's care documents did not always reflect their capacity to make choices about their day.

People did not always receive the nutritional support they needed. One person was placed at risk of choking.

People's needs were met by care staff who had access to training, effective supervision and professional development. People were supported with healthcare appointments.

Is the service caring?

Good

The service was caring. Care staff and nurses knew people well, what was important to them.

People's dignity was promoted and care staff assisted them people to ensure they were kept clean and comfortable. Care staff engaged with people positively whilst assisting them with mobility around the home.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were left without stimulation or engagement from care staff for long periods of

time. Care staff did not always take opportunities to engage with people.

People's care records did not always reflect their needs and were not always personalised. People's care records were in the process of being updated as the manager was aware of these concerns.

People and their relatives told us they felt involved and their concerns and complaints were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led. The provider had not ensured that systems were in place and regularly undertaken to sufficiently assess, monitor and continually improve the quality of service people received.

There was a recently appointed new manager who was applying for registration with the CQC. The manager had a clear plan of how they planned to develop and improve the quality of service people received.

Deanwood Lodge

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 was 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 the 6 January 2016 and it was unannounced. The inspection team consisted of three inspectors.

At the time of the inspection there were 34 people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We also spoke with healthcare professionals, including social care commissioners and safeguarding teams.

We spoke with five people who were using the service. We also spoke with four people's relatives and two people's visitors. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with four care staff, the clinical lead, the manager and a representative of the provider. We reviewed seven people's care files, three care staff records and records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

People could not be assured the premises were safe, as regular safety checks of the premises had not always been carried out in accordance with the provider's policies. Fire safety and maintenance records showed not all safety checks and procedures were carried out regularly. For example, a fire safety drill had not been carried out since May 2015. Monthly checks of nurse call bells, window restrictors and bed rails were not being completed on a monthly basis. Electrical portable appliance testing (PAT) had not been completed since 2014. Where safety checks had been completed, appropriate action had not always been taken in response to the findings. For example; water temperature records for November and December 2015 indicated five hot water outlets were above the recommended safe temperature which could lead to a person being scalded however no action had been taken to rectify this.

People who spent some of their time walking with purpose around the home were not always protected from risks in their environment. For example, rooms which contained equipment and chemicals that could harm people were not always secured. A room containing sluice machinery was not always secured. This room also contained other risks to people due to loose fixtures.

A maintenance person had been appointed in November 2015. We discussed our concerns with the manager and a representative from the provider. They informed us they were aware of the concerns, and would assist the maintenance person to ensure checks and immediate corrective measures were carried out as required.

These concerns were a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People had been assessed where staff had identified risks in relation to their health and well-being. These included moving and handling, mobility, agitation, nutrition and hydration. Risk assessments gave staff guidance which enabled staff to help people to stay safe. Each person's care plan contained information on the support they needed to assist them to be safe. For example, one person was at risk of pressure sores, had information on how they should be assisted with their mobility and the pressure relief equipment they needed.

For two people, pressure relief air mattresses had not been set in accordance with their weight, which increased their risk of damage to their skin integrity. We discussed this concern with the manager who took immediate action to ensure all pressure mattresses were set in accordance with people's needs. They were also planning to provide clear instructions to staff, to ensure this concern did not reoccur.

People told us they felt safe in the home. Comments included: "I'm safe, thank you" and "I'm alright". A relative told us, "I think they're safe. I have peace of mind".

People were protected from the risk of abuse. Care staff had knowledge of types and signs of abuse, which included neglect, and understood their responsibility to report any concerns promptly. Staff told us they

would document concerns and report them to the registered manager, or the provider. One staff member said, "I know where to go if I have any concerns". Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to local authority safeguarding or the CQC. They said, "I couldn't standby and do nothing". Staff told us they had received safeguarding training.

The manager and a representative from the provider raised and responded to any safeguarding concerns in accordance with local authority safeguarding procedures. Since our last inspection the provider had ensured all concerns were reported to local authority safeguarding and CQC.

People and their relatives told us there were enough staff to meet their needs. Comments included: "They are always around"; "I don't have to wait long for help"; "Always staff around, don't see a problem" and "It seems better. There's a lot more staff on the floor".

There was a calm and homely atmosphere in the home on both days of our inspection. Staff were not rushed and had time to assist people in a calm and dignified way. Staff told us there were enough staff available on a day to day basis to meet people's needs. Comments included: "Staffing levels have got better over the last couple of weeks. We had agency, which was difficult, but we only had one last week" and "I think we are okay, staffing has increased, and we've taken action to ensure people are cared for". The manager and a representative from the provider had identified the number of staff needed to ensure people were kept safe. Staff rotas showed on the days of our inspection and other days, there were an agreed number of staff in line with the providers expectations deployed to meet people's needs. The manager stated that two activity staff had been recruited, but had yet to start. Two nurses were being interviewed for night duty as this was currently being covered by agency nurses five nights per week

Records relating to the recruitment of new care support workers showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure support workers were of good character.

People received their medicines as prescribed. Nurses and care staff assisted people to take their medicines as prescribed. Staff gave people time to take their medicines, and ensured they were taken. One person was administered their medicines covertly. Staff had clear guidance about what medicines could be given covertly, and how they should be given. The person's medicine administration records clearly showed they received their prescribed medicines in accordance with the GP's instructions to administer medicines covertly.

People's prescribed medicines were kept secure, and staff ensured when medicines were taken from the branded and labelled boxes that the date the boxes were open was recorded. This enabled staff to ensure people's medicines were not inappropriately used. However staff did not always maintain an accurate record of the stock of people's medicine stocks.. For one person staff did not always consistently record, when they refused their medicines. This meant staff did not always have a clear record of the support they provided a person who regularly refused their medicines. The home's clinical lead told us they would make changes to ensure people's medicine administration records were accurate.

Requires Improvement

Is the service effective?

Our findings

People were not always protected from the risk of choking. For example, one person required thickened fluid and a soft pureed diet as they were at risk of choking. Staff provided this person with drinks which had been thickened, and gave them a main meal which was pureed. However the person was given a pudding of their choice, which had not been pureed. The person started to eat their meal independently, however struggled and started to choke. A staff member intervened to ensure the person was safe. We discussed this person with staff who informed us they knew the person's needs and had tried to mash their pudding. The person was not concerned by the incident.

We discussed this concern with the manager who informed us they were discussing this person's needs with healthcare professionals. They reinforced that all staff should ensure all food is pureed to protect the person from further risks.

These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People and their relatives told us they enjoyed their food. Comments included: "It's lovely, I enjoy it all", "It's very nice thank you" and "They've always been fussy, however they seem to enjoy all the food here".

People's dietary needs were known by staff. The home's chef was aware of people who required special diets, such as diabetics, people with coeliac disease and those with swallowing problems. They also told us they were informed of when people had lost weight and required their meals to be fortified by using full fat milk, cream and butter for food such as mashed potatoes and soup. People were also had access to full fat yoghurts, cakes, biscuits and snacks between meals. One relative spoke positively about the support their relative had received following a recent unexpected loss of weight. They told us, "They like soup and staff get it for them."

People who could not eat independently received assistance and support from care staff. We observed one member of staff assisting a person with their main meal. They sat at the same level as the person and did not rush them. The staff member ensured the person had finished each mouthful before they proceeded.

People were often supported to make choices around their daily needs, including where they wished to have their meals, and what they liked to eat. Some people had been assessed as not having the capacity to make their own decisions, however the records of their mental capacity assessments did not always reflect people's needs and abilities. For example, one person's mental capacity assessment stated they did not have the capacity to make any decisions regarding their care and required full support to choose meals and clothing. The person's care plans however documented how staff should support them to enable them to make day to day decisions such as what they would like to eat or drink. One staff member said, "I often provide two choices, this gives a choice to the person, however doesn't give them too much choice, which they would struggle with".

People's mental capacity assessments did not always document the involvement of people's relatives or healthcare professionals when best interest decisions had been made. For example, one person's care plan contained a mental capacity assessment and best interest decision for a stair gate to stop other people going into their room. The assessment had been signed by two people; however there was no indication of who these people were.

Staff had undertaken training on the Mental Capacity Act (MCA) 2005. 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff showed a good understanding of this legislation and were able to cite specific points about it. One member of staff told us, "It's all about choice; you've got to ask. Freedom of choice of meals, clothing, what they want to do". Another care worker said, "For bigger decisions there's power of attorney, family, GP or social workers".

We discussed these concerns with the manager and a representative for the provider. They informed us care plans were being rewritten and a new mental capacity assessment was being used. We looked at rewritten care plans for two people, which clearly documented their mental capacity and the day to day decisions they could make.

For one person a best interest decision had been made as the person no longer had the capacity to understand the risks to their health if they left the home without support. The manager made a Deprivation of Liberty Safeguard (DoLS) application for this person. 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).

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People and their relatives told us that care staff had the skills they needed. Comments included: "Very, very good. There's better care at this care home than in hospital. I'm very satisfied"; "The new nurses are excellent" and "They are very good here".

People's needs were met by care staff that had access to the training they needed. Comments by staff included: "I was trained well. They made things really clear so I could understand" and "Definitely have the training I need". Care staff told us they had the training they needed when they started working at the home, and were supported to refresh this training. Care staff had completed training which included safeguarding, fire safety and moving & handling.

Care staff told us they had been supported by the registered manager to develop professionally. Some staff had obtained NVQ's (National Vocational Qualifications) in health and social care at level 2 and 3. Others had undertaken training sessions on dementia awareness and one was the dementia link trainer for the home.

Care staff had access to supervisions (one to one meeting) with their manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff also told us they could always meet with the manager to discuss concerns when necessary.

People had access to health and social care professionals. Records confirmed people had been referred to a GP, dentist and an optician and were supported to attend appointments when required. People's care records showed relevant health and social care professionals were involved with people's care. For example, records of appointments with healthcare professionals were clearly documented on people's records. The clinical lead nurse said that the home received a visit from a General Practitioner (GP) every other week, or on request. They had a list of contact numbers of other health and social care professionals if required.

Good

Is the service caring?

Our findings

People and their relatives had positive views on the caring nature of the service. One person said, "They treat me really well, thank you. The girls are all very nice". A relative responded positively when asked about the staff, they also told us, "They (the staff) keep her nice and clean; which I know she likes".

Care staff interacted with people in a kind and compassionate manner. Staff adapted their approach and related with people according to their communication needs. They spoke to people as an equal. They gave them information about their care in a manner which reflected their understanding. For example, one staff member took time to talk to someone who spoke quietly. They sat close to the person, so the person could see their face. The staff member was patient and took time to hear what the person wanted to tell them. The person enjoyed their conversation with the staff member. They told us, "I like talking to them. They do sit with me".

Care workers knew the people they cared for, including their likes and dislikes. When we discussed people and their needs, all staff spoke confidently about them. For example, one care worker was able to tell us about how one person, who was unwell on the day of our inspection. Staff told us what was important to the person and how they supported them to be comfortable in the home.

People were cared for by care workers who were often attentive to their needs. For example, care staff knew when people's needs had changed and ensured the support they needed was provided. One person had refused any fluids, food and their medicines. Staff told us how they communicated with the person's family and healthcare professionals to ensure the person was supported in the home. One staff member said, "We encourage support and have arranged for medicines to be given covertly. When they are in a happy mood we spend time with them".

People were able to personalise their bedrooms. One person had items in their bed room which were important to them, such as pictures of people important to them. One person liked to keep their bed room private and had requested a small gate be in place to maintain their private space from other people living in the home. This person's wishes had been respected and their consent had been sought for this gate.

People were treated with dignity and respect. We observed care workers assisting people throughout the day. Care staff told us how they ensured people's dignity was respected. One staff member assisted someone with their personal hygiene in a dignified way. They ensured the person's dignity was maintained and supported them back to their room, where they assisted them in the privacy and comfort of their room. The staff member told us, "It's important to act to make sure people are safe, comfortable and live with dignity".

People were supported to make advanced decisions around their care and treatment. For example, one person was asked for their views of where they would wish to be treated in the event of their health deteriorating. The person, with support from their family had decided they wished to be cared for at Deanwood Lodge and not go to hospital for any treatment which may prolong their life and not improve the

quality of their life. A Do Not Attempt Cardio Pulmonary Resuscitation form was in place which stated they did not want to receive active treatment in the event of heart failure.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support in accordance with their personalised needs. For example, people were not always given choice around their food and drink. One staff member gave someone a cup of tea, and some biscuits. They did not offer the person a choice. The person ate some of the biscuits, however the cup of tea was out of reach and they were not supported with this.

People did not always receive the support they needed with their dietary needs. For example, people were given there meal, however had to wait periods of time up to 15 minutes before support was available for them to eat their food. People's food could become cold before they started their food, as it was not always served when assistance was available.

Another person was given their lunch time meal whilst they were sleeping. Staff left the food in front of the person for 15 minutes before they took it away. One staff member said, "They often have a very big breakfast, which they did today, so they're often asleep or full at lunch. We make sure they can have their meal later". Staff told us they ensured the person had their main meal later.

People did not always have access to activities and interests which they enjoyed. There were limited activities for people living in the home. For example, in one lounge people were watching television, whilst another lounge people were listening to music. While the home had an activity co-ordinator employed, they were leaving the service shortly. On the day of our inspection there were no planned activities, and the atmosphere in the home was very subdued. One person told us, "It's boring here. I used to be going out all the time". A visitor said, "There doesn't always seem to be a lot going on".

People did not always have support from staff to meet their social needs. Some people went without engagement from staff for periods of time of around 30 minutes to an hour. For example, we observed staff sitting with people, however they did not take opportunities to engage with them, through conversations or ad hoc activities. One staff member was sat with three people, however only engaged with people when they asked for assistance.

We discussed our concerns with the manager and a representative from the provider. They told us that two new activity co-ordinators were being recruited shortly. They felt the atmosphere of the home was quiet on the day of the inspections, and this was not always reflective of the atmosphere in the home.

These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We spoke with the activity co-coordinator who told us about some of the activities they provided in the home, such as baking. They said, "On baking day people can still remember the movements of baking. To see that makes me really happy". The activity co-ordinator also told us they had provided a variety of activities including trips to the local pub, walks around the lake when the weather was suitable, and singing events. They had also arranged a beauty therapist to visit and carry our pamper sessions with people. To

prevent social isolation the activity coordinator told us they ensured they regularly visited people in their rooms and spent time with them doing one to one activities like reading.

People's care needs were documented in their care plans; however, there was not always clear guidance for care staff to follow to meet people's needs. This put people at risk of not receiving the care and support they need. For example, one person's care plan did not provide clear information on the support they needed with wounds on their legs and how often dresses would be replaced. Information about people's emotions and items which were important to them were not documented. For another person, there was limited information about the support the person needed around their dietary needs, even though staff had raised concerns over the person's risk of malnutrition. When we discussed these people with staff, they were able to tell us about their needs and had provided the required support.

We discussed these concerns with the manager and a representative of the provider. They informed us they were currently reviewing and updating all people's care records. They had reviewed a number of records to ensure they reflected people's care needs and were planning to ensure all information was personalised to people's needs. One staff member said that they felt that people's new care plans helped them understand their needs. They told us, "Yes I use them; they are very good, useful".

People and their relatives knew how to make complaints to the provider. People confirmed they knew who to speak to if they were not happy. One relative told us, "I have raised a concern and they are taking action". Another relative said, "I would go to the manager if I have any concerns, I'm confident they would take action. The manager kept a log of compliments, concerns and complaints. Some complaints made to the service had not been investigated in the accordance with the provider's complaints policy. We discussed this with a representative for the provider who informed us all complaints were investigated, however due to the scale, this complaint had not been able to be concluded within the provider's timeframes. Where complaints or concerns had been substantiated the service implemented actions to ensure these concerns were not repeated.

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager at the time of the inspection. There was a recently appointed new manager who was applying for registration with the Care Quality Commission (CQC). The manager had previously worked in the home as a senior member of the care staff and had been promoted. There was also a new clinical lead appointed to the home who had started in November 2015.

The manager felt a voluntary embargo on people with nursing needs coming to the home was needed due to the recent changes of staff, an identified shortfall in care plan reviews and the need for further nurse recruitment. This would be lifted when the manager was assured that there were enough suitably skilled staff and that those people with nursing needs that were currently in the home had all their care reviewed and updated. For this reason, the manager had begun an action plan looking mainly at recruitment and record keeping.

The manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been notified of these events when they occurred.

The manager was supported by an operations manager through regular contact. The manager said that he had "learnt on the job". However he was also currently undertaking a level 5 leadership and management course, as was the clinical lead.

Communication between staff about daily changes and occurrences in the homes were undertaken in an informal way with no record of it having taken place. The manager acknowledged that a record of any communication would be useful. He stated that he planned to have regular staff meetings going forward.

There were no planned resident and relative meetings as the manager felt that they were of limited value. Instead the manager intended to send out regular newsletters that communicated any changes going on in the home. Newsletters do not allow people to feedback their own thoughts, ideas or concerns but the manager stated that people and their family's views about the service were to be sought through comments cards which were going to be set up in the reception. He also stated that they could ring or email him at any time. However there was no evidence provided which showed that people's views helped to drive improvements in the home.

People were not assured that suitable audits of the quality of the service being provided were being carried out. For example, there was no evidence of on-going quality assurance checks around significant areas of care such as infection control and health and safety. Quality assurance processes undertaken by an external auditor had been discontinued in 2015. The manager felt they were not effective in allowing him to see where there were shortfalls in any of the quality systems. The manager explained that he planned to visit an experienced manager in another of the provider's homes who would share with him audit templates that he could then use going forward.

Currently medicines were audited on a weekly basis by the clinical lead and the manager audited a sample

of care plans on a weekly basis. However there was no evidence on the care plan audit forms of the date any actions identified were completed, how they were completed and by whom. The manager acknowledged that this was an important part of the audit process to ensure that actions were undertaken and learning could be evidenced.

The provider had not ensured that systems were in place and regularly undertaken to sufficiently assess, monitor and continually improve the quality and safety of the services provided, including the quality of the experience of service users in receiving those services.

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

Accident and incidents that occurred in the home were monitored. The manager said that he used this data to identify any areas or patterns of concerns. For example the data allowed him to pinpoint specific locations and times when falls were more prevalent and this meant that he could ensure more staff were in place at this time to keep people safe.

The manager felt that the home's core value was "to deliver quality person centred care". Staff also said that for them people were the most important part of their role. One member of staff said "The main focus here is to spend time with the residents".

The manager said that he had an open door policy and would make regular walks around the home to ensure he was visible and that he could observe care being delivered and check on care plans and building maintenance issues. The manager was confident that staff were able to come to him with any feedback or concerns. Staff told us that the manager was approachable and always ready to listen to and discuss ideas about how to improve the service .A member of care staff said "I think he's (the manager) great. He knows his stuff and is approachable". Another member of staff said "He's (the manager) always available. If I want something, he'll get it".

Staff demonstrated a clear awareness and understanding of whistleblowing procedures within the home and where outside agencies should be contacted with concerns. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

The manager felt that the main challenges facing the home were the ability to recruit quality staff. This was echoed by senior staff in the home who also felt that staffing was the main challenge.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's care and treatment was not always appropriate or reflective of their needs and preferences. Regulation 9 (1)(a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People did not always receive safe care and treatment. Regulation 12 (1) (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	People were not protected against the risks associated with unsafe or unsuitable premises because checks to ensure the property and fire systems were fit for purpose had not been carried out. Regulation 15 (1) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems had not been developed sufficiently assess, monitor and improve the quality and safety of services provided. Regulation 17 (2) (a).