

Carlton Hall (Lowestoft) Limited

Carlton Hall Residential 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

Carlton Hall residential home is registered to provide accommodation and personal care for up to 56 people. At the time of our inspection there were 53 people using the service. The service comprises a main residential home [which also includes a separate unit for people living with dementia], and a building external to the main residential home called "The Granary". People using the service were older adults whose needs were associated with physical disability, dementia or long term conditions.

Personal care could also be provided to the owners of twenty five purpose-built modern bungalows located within the grounds of Carlton Hall, if they required this. Their care was provided by Carlton Hall care staff, but people could also choose their own provider if this was their preference. There were 11 people receiving the personal care service at the time of the inspection.

There was 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 2008 and associated Regulations about how the service is run.'

During this inspection, we found that the registered provider was in breach of three regulations 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 the report.

The provider had not ensured that there were sufficient numbers of skilled and knowledgeable staff to meet people's needs. Staffing levels were not always adequate to ensure that people were kept safe at all times.

Staff were kind and caring in their interactions with people. However, at times care was task focussed and hurried with staff unable to respond to people as quickly as they would like.

There were gaps in how the service assessed and monitored the quality of its provision. Whilst there were some quality assurance mechanisms in place, not all aspects of the service were being effectively monitored.

Staff received training relevant to their role, but needed further training in relation to dementia care. We have made a recommendation about the specialist needs of people living with dementia.

The dining experience was not conducive to an enjoyable mealtime and opportunity for social interactions. We have made a recommendation about improving the dining experience for people.

People's care records were updated and amended to changing needs. However, not all records included guidance for staff on how to support people with their emotional and social care needs. Having this information would help staff to tailor individual needs more fully.

People were asked for their consent before any care, treatment or support was provided.

Risk assessments were completed to ensure that people were kept safe. These included risk assessments in relation to people's personal care, moving and handling, falls and medicines.

Systems were in place for managing medicines and people received their medicines in a timely manner. However, protocols were not in place for people receiving their medicines 'as required'.

Activity provision was not sufficient to meet the individual and specialist needs of people using the service.

People's individual needs were not always met by the design or decoration of the service. We have made a recommendation on improving the design and decoration of accommodation for people living with dementia.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse, and who they should report this to. Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

People and relatives said if they needed to make a complaint they would know how to. There was a complaints procedure in place for people to access if they needed to.

There was an open and transparent culture in the service. Staff felt listened to and were able to raise their views openly.

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.

Staffing level arrangements were not sufficient to ensure people's needs were met at all times.

Systems were in place for managing medicines and people received their medicines in a timely manner. However, protocols were needed for medicines that were taken 'as required'.

Risks were identified and reviewed in a timely manner.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Staff required further training to ensure that the care delivered was effective.

Improvements were needed in people's mealtime experience.

People were asked for their consent before any care, treatment or support was provided.

People's nutritional needs were assessed and professional support was obtained for people when needed.

Is the service caring?

Good ●

The service was caring.

We observed staff to be kind and caring when interacting with people. However, sometimes care was task focussed as staff did not always have the opportunity to ensure interactions were meaningful.

People's views were listened to, and people were supported to see their relatives and friends.

People's privacy was supported and respected.

Is the service responsive?

The service was not consistently responsive.

Care records were updated in line with people's changing needs, but did not always include information on their social and emotional needs.

Activity provision was not sufficient to meet individual needs.

There was a complaints procedure in place. People and relatives knew how to complain.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

The provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

Some audits were completed to assess the quality of the service; however these were not always effective in highlighting areas for improvement.

Not all aspects of the service were being effectively monitored to ensure quality was not compromised.

There was an open and transparent culture in the service. Staff felt able to voice their opinions and had confidence in the management team.

Requires Improvement ●

Carlton Hall Residential 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 30 November 2016, was unannounced and undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection 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 also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us, for example, people living with dementia.

During the inspection we spoke with 13 people living at the service, eight visitors, including friends and relatives, and one visiting health professional. We also spoke with the registered manager, service manager, domiciliary care manger, and 10 members of care and catering staff. Following the inspection we spoke to the Nominated Individual for the provider. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed 11 people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Is the service safe?

Our findings

People, staff, and relatives told us they did not think there were sufficient numbers of staff on duty in the Granary and residential part of the service to meet people's needs. One person told us, "Some people are very incapacitated, others are more in need [than me]. I feel quite strongly that they do need more staff. I feel they need more support". A staff member said, "They need more staff, we've got a lot of doubles assists [two carers needed to support personal care and movement] it's just not enough". A relative said, "They do need more staff. It's no good having a posh building if there is no care. They definitely do need more".

There were eight people who needed two carers to support personal care and movement [on the Granary and dementia unit]. They sometimes had to wait to receive the support and care they needed because at times, staff in the Granary [separate building] had to radio another staff member in the main residential home and request assistance. Staff confirmed this to be the case, and said that this also happened at night. This also posed a risk to people in the main residential home, as there were three staff on duty at night, and 10 people requiring support from two carers. If two staff were needed to assist a person to move or to use the toilet, there would be no one available to monitor the welfare of other people. There was no information available to show that the risk had been assessed, and did not demonstrate sufficient staff were deployed to cover both the emergency and routine work of the service.

The service had increased the number of placements due to a new unit opening, but had not considered the impact of the increase and how it would affect the wider service. The registered manager told us that they intended to start analysing the staff rotas more thoroughly, and consider people's care needs alongside this. Despite this plan, there had been no assessment in the interim to mitigate any immediate risk to people. There was no process in place to ensure a systematic approach to determine the number of staff and range of skills required in order to meet the dependency needs of people using the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People receiving care in the on-site bungalows felt that staffing levels were sufficient. This staff group are carers employed by Carlton Hall, but provide care specifically to the people living in the on-site bungalows. One person said, "You've only got to press the button, if you're frightened or upset, and they come". Another said, "They [staff] come straight away". A staff member said, "With people living in the bungalows, you have more time to sit and chat. Our manager is very hands on too, they don't just sit in the office, they always help out". Therefore there was a lack of consistency across the service in relation to adequate staffing.

Systems were in place for managing medicines and people received their medicines in a timely manner. One person told us, "us "They [staff] come and find me, tell me what my medication is for. They bring them [medicines] in a little glass, tip them out into my hand, one or two at a time. Staff always bring a glass of water to drink with it". Another said, "They [staff] know what they're doing, I have two paracetamol three times a day. I have to have them for the pain".

Medicines [including controlled drugs] were stored securely, with appropriate facilities available for

temperature sensitive medicines. For people receiving medicines "As required" [PRN], there were no protocols in place for staff to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling, and would provide staff with information, such as symptoms a person may display if they were in pain. One person was prescribed medicines for agitation, but there was no clear information on interventions which may work to reduce the agitation before the medicines were considered. Though staff were trying to work in the best interests of the person, the lack of information in the records meant that the person may not receive the medicines they needed. Having a protocol in place would reduce the risk of medicines being given when they may not be needed.

There were Personal Emergency Evacuation Plans (PEEP) in place. These showed the support people required to evacuate the building in an emergency situation. However, these needed more detail. For example, some plans said that two staff were needed to evacuate safely, but no other details about the method to be used. Additionally, there was no guidance available for people living with dementia, and how staff could effectively reassure them in the event of an emergency.

Risk assessments provided staff with guidance on how risks to people were minimised. There were a wide range of risk assessments [For people in residential and domiciliary care] such as skin integrity, use of bedrails, moving and handling, falls, and nutrition. Risk assessments were regularly reviewed and amended to reflect changing needs.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "If I had any concerns about people being at risk, I would contact the safeguarding team. I wouldn't wait". Another said, "I know the types of abuse to look out for, and I would definitely take action".

People received care and support from staff who had been appropriately and safely recruited. Recruitment files we viewed confirmed that references and a criminal records check had been completed to ensure staff were suitable for their role.

Equipment was serviced to ensure it was safe for use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

Is the service effective?

Our findings

Staff received training relevant to the people they were caring for. For example, safeguarding, medicines, and moving and handling. Some staff had undertaken an "Introduction to dementia" workshop. However, we saw that staff had not received any training in relation to supporting people who may display behaviours which challenge staff, and several people in the service were living with advanced dementia which caused them to experience anxiety and behaviours which challenged staff at times. This meant that staff required greater levels of understanding of the condition in order to meet the specialist needs of people living with dementia. We saw that an incident had occurred between a person and a staff member in November 2016. They were the only member of staff on duty in the unit at that time, and had to call for assistance from a staff member working in the main residential building for support.

We raised our concerns with the registered manager, who told us that they were aware of the need for more advanced dementia training for staff, and had booked this for January 2017.

We also recommend that the service explores current guidance from a reputable source, [such as the Social Care Institute for Excellence or the Alheimers Society] in relation to supporting staff to manage the specialist needs of people living with dementia, and the range of approaches and interventions which can be considered in meeting people's individual needs.

People commented on how well staff met their needs. One person said, "I can honestly say that they [staff] know me well and understand my needs, yes, most definitely". Another said, "If the junior's not sure they will go and ask the senior".

Staff received an induction before they started working in the service, consisting of mandatory training such as moving and handling and safeguarding. The registered manager told us the induction lasted over a 12 week period and included shadowing experienced staff to gain knowledge of the role. A "Staff mentor" position was created at the start of this year to help introduce new staff to the team, share good practice, and have a named member of staff to assist them to settle in their role. A high proportion of staff were undertaking the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work.

Supervisions and appraisals provided staff with the opportunity to discuss how they were working, receive feedback on their practice and identify how they would like to develop their skills. Records showed that training was discussed as part of the meetings, as well as any support staff needed from the management team.

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 decision 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 MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

DoLS applications had been made to the local authority as required to ensure that any restrictions on people were lawful. People's care records made reference to their mental state and ability to make decisions, including MCA assessments. These included everyday decisions including action which might be taken in the best interests of the person, and more complex decisions associated with treatment by healthcare professionals. Records also included documents which had been signed by people to consent to the care provided as identified in their care plans.

We did however note that three of the capacity assessments gave a repetitive answer to the question, "Do you think the person understands the information relevant to the decisions?" And the answer given was "[Person] has never made any attempts to leave the building. [Person] does not appear to want to leave". The answer did not relate to the question asked, and we brought this to the attention of the registered manager who told us they would look into this and staff understanding of the assessments.

People's nutritional needs were assessed and monitored. Food supplements were used to increase nutrition and people who had problems with swallowing were served softer diets and thickened fluids. People told us they enjoyed the food they were served. One person said, "Yes I do enjoy the food, and there's plenty of it". Another said, "The food is very good, some is extra special, it's not dull food. Some is meat and veg but there are some very special things as well, lovely desserts".

We observed the lunchtime meal in the dementia unit. The atmosphere was not conducive to a positive dining experience. There was no indication that lunch was about to be served, the tables were not laid and drinks were not offered. A member of staff told us, "Drinks come after the main meal, it's less distracting [for people]". People were served at the table first and the people seated in the lounge area had to wait. People had to wait for their dessert to arrive as the staff had to call for this to be delivered. One person was offered a blue plastic apron to protect their clothes whilst they were eating. We observed that the person began to eat pieces of the apron. We brought this to the attention of a staff member, who removed the pieces from their mouth, but a short time later the person started to eat this again. Staff did not notice this whilst they were busy serving lunch. A member of staff told us that people usually wore fabric tabards to protect their clothing when eating, but they were in the laundry.

We observed a similar situation in the main residential dining area. People were eating at different stages, which did not enhance the opportunity for social interactions, as people were looking around for their food. We asked one member of staff if they felt they had enough time to support people with their needs during lunchtime. They told us "I feel sometimes we are helping one person when we could be serving someone else, just lately more people have needed extra help". People appeared relaxed despite the fact that staff were going from one person to another with the constant interruption of loud radio conversation between staff [Staff carry handheld radio devices to communicate with each other].

The Granary unit is a separate wing to the main residential home, but has its own living room, dining room and kitchen as well as a secluded courtyard. The provider told us that activity staff provided sessions to people in this unit. However, we observed that people using this part of the service were removed from the ambiance of the main home and the day to day activity that was taking place.

Personalisation of the entrances to people's private rooms and the use of visual signage would benefit

people using the service, particularly those with a sensory impairment and those living with dementia.

We recommend that the service explores current guidance from a reputable source [such as the Social Care Institute for Excellence or Alzheimer's Society] on improving the design and decoration of accommodation for people living with dementia.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. There was also a weekly clinic set up with the local surgery, where a GP visited the service and carried out health checks. One person told us, "The doctor and nurse come regularly which is an advantage, you get good medical attention". A relative told us how the service had contacted a physiotherapist for their relative. "They are looking into [relatives] leg problem. They [staff] get people in. They know the procedures".

Is the service caring?

Our findings

People and relatives told us that staff were kind and friendly. One person said, ""They're [staff] all so very helpful and nice, you don't get that in a lot of places". A relative said, "Staff are very nice and friendly, and there is a warm atmosphere".

We observed kind and caring interactions between staff and people. One member of staff when referring to people who lived on the dementia unit, told us "They're used to our faces, the staff are calm and happy, and it's just nice to have the same faces work over here, it's very happy. We can look into one of the resident's faces and know if something's wrong". However, the service did not always promote opportunities for staff to engage with people in a meaningful way. This was because staff were seen to be under pressure when supporting people due to staffing levels. One member of staff told us, "There is not enough time to spend with people, as we have to rush from one person to the next, and the little things get missed". Another said, "When you rush you don't do the job properly". Staff we spoke with demonstrated a caring approach to the care they delivered, and wanted to spend time just chatting with people. However, at times we observed care to be task focussed which could impact on ensuring people's dignity was respected. This was not the fault of the care staff, but rather a situation which had developed due to staff shortages, and which should have been identified by the management team.

People's care records included forms which had been signed by people [or their advocates] to consent to their care, demonstrating their involvement. Statements were constructed by people, for example, a clear description of how they liked their personal care to be carried out, and how one person "Took pride in their appearance" and another was, "A private person who valued their independence". We asked people if they were involved in creating their care plan. One person said, "They [staff] have asked me about a lot of things, of my past and family life, they're always eager to know more". Another said, "Yes, they ask me about how I like things done".

People's Independence was promoted. One person said, "My aim is to be as independent as possible, the staff are there to help you think for yourself, that can only be good. I'm doing what I'm capable of, they [staff] invite me to do things, they want me to get better". Another said, "They [staff] stand outside [the bathroom] and come in if I need help. I like to try to do things for myself".

There were copies of the service's current newsletter in people's rooms so they knew what was happening in the service. People were given the opportunity to express their views in resident meetings, which were held quarterly, and the registered manager told us these would be held more frequently in the future. We observed a notice informing people using the service of a "resident's" meeting to be held on the day of our inspection. We joined the meeting and saw that relevant items were discussed [such as upcoming activities] and people were asked if they were happy, or if there was anything else they would like to do. Each person was asked in turn if they had any items to raise, and one person asked if the lighting could be made brighter in the lounge. This was discussed by the chair person, who said they would ask maintenance to look into this. Another person raised concerns about how busy staff were and said, "Staff have too much to do and too many people to manage, this can delay things". This comment was reflective of what we had observed.

Relatives told us that they were always made to feel welcome when they visited and that they could visit at any time. This meant that people were able to socialise with family and friends as they chose and this reduced the risk of social isolation. We saw relatives who were visiting, and chatting comfortably with staff. One relative said, "I come in regularly, I can come anytime".

Is the service responsive?

Our findings

People's care records included care plans which guided staff in the care that people required and preferred to meet their needs. We could see that the service had spent a lot of time developing these and ensuring information was current. Good examples included how people liked their personal care delivered, their personal preferences, and other important details such as wanting to remain independent and how staff could support them to do so. However, people's care plans were not always fully focussed on a person's whole life, including their emotional and social care needs. For example, some care plans provided little information about how the person wanted to live their life at the service, and how they could be enabled to do so. Information relating to people's life history was also not consistent across the service. Having this information supports staff to have meaningful conversations with people about their lives and what is important to them. This is particularly important for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness.

We observed that there was minimal activity taking place across the service. On the dementia unit, three people were sitting at a table doing very little for much of the morning. One person had a 'tactile glove' [A sensory therapy glove with stimulating fabrics and attachments] but repeatedly banged the table and talked to them self. Nobody intervened or tried an alternative activity to help settle or distract the person. One person's care plan said "I do not like to be in large groups", but they were in the main lounge for most of the day with everyone else. A relative said, "Staff do not have time for regular one to one time with [person]". Another relative said, "Social activities could be better, they [staff] do their best, but I often think [relative] would thrive if they were stimulated more".

The registered manager informed us that the current activity coordinator was on leave, but was returning in January 2017. Another person had been put in place to cover their period of leave. With the increase of people living in the Granary unit, the provider told us that it had been agreed to retain a second activity co-ordinator going forward. The activity co-ordinator told us, "It [activities] makes the resident's happy. It will be a lot easier when the other activity co-ordinator comes back, but [care] staff help out as much as they can. Some [people] I might play snakes and ladders with. I do small activities with three to four people. I do one to ones. I hand out an activity sheet which tells them [people] what is going on during the week. That has helped". They were clearly committed to their role and told us, "It's important to stimulate the brain. In the dementia unit I do reminiscence, painting, colouring, and singing".

Records kept of people's participation in activity did not always demonstrate what people had been involved with, and some people had no entries on their activity log. We could therefore not be assured that there was sufficient activity provision across the service to meet people's individual and specialist needs.

All of the above constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt staff were responsive to their needs. One person said, "They [staff] do try to make time, they always say "how are you"? They listen if you say anything, act upon anything you're worried

about". I'm definitely reassured that they [staff] would try and help, they do their best". Another said, "I feel that staff do listen to me, they want to help".

The service had a complaints procedure for people, relatives and visitors to raise concerns. Complaints were responded to in a timely manner, logged and action taken to find solutions. For example, we saw that action was taken in response to a complaint concerning a religious practice which was not available in the service. This was made available and a suitable space organised.

Is the service well-led?

Our findings

The service had a registered manager in place. They had been temporarily absent from the service but a service manager had been brought in to provide support and leadership in the interim. There was also a manager in place to oversee the domiciliary part of the service. The registered manager told us that they had made a decision to 'step down' from their role soon and commence a 'quality assurance' role within the service, enabling them to carry out internal audits, supervision of staff, and act as a liaison for people and relatives. The service manager intended to replace them in the role of registered manager. We were subsequently informed by the provider following the inspection that the service manager was no longer working in the service. The provider had however, identified another member of staff they were developing to support the management team going forward, and was also working closely with the management team to ensure improvements were made.

There was a lack of oversight which resulted in no action being taken to ensure improvements were made. The management team knew that staffing levels needed to be reviewed but this had not been analysed sufficiently to mitigate risks. The registered manager told us that now they were back in the service they were going to start looking at staffing levels more closely, especially as the service had expanded, and were adding additional staff to the rota as needed. Dependency ratings were completed, but kept in people's care records, and were not being used to calculate staffing levels.

Audits were not adequately identifying all the shortfalls in the quality of the service. There was a lack of analysis of quality assurance systems to continually monitor the service provided to ensure people received safe and effective care at all times. Some audits had been completed in areas such as call bell response times and medicines, and some actions had been taken. However, a medicine audit this year [May, June, and August] said that PRN protocols were in place. A further audit in November identified that PRN protocols were not in place, and we did not see any completed when we checked. Additionally, call bell response times were not being analysed or monitored in the Granary to demonstrate that staff were deployed at peak times, or where to focus resources. No further consideration had been given to the amount of staff needed in the Granary as a result of people being at high risk of falls.

We saw that a serious incident had occurred [November 2016] on the dementia unit which was discussed in a team meeting. It stated that "Staff were concerned that there is only one carer on duty at night". The answer in response to this was to "Arrange further dementia training". The management team had not considered increasing staffing levels to ensure people and staff were safe at all times. We also saw that staff had raised concerns regarding staffing levels as far back as June 2016.

We noted that lunchtime feedback forms had been completed in October 2016 to ask if people had enjoyed the food. However, these had not identified issues related to people's experience or the availability of staff to assist during mealtimes.

We recommend that the service explores current guidance from a reputable source [such as the Social Care Institute for Excellence or Alzheimer's Society] to ensure that mealtime experiences are an opportunity to

support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said that the registered manager was available, accessible and gave practical support, assistance and advice. Staff were clear about their roles and responsibilities, and were able to describe these well. One staff member said, "I feel valued in my role. I have confidence in them [management team], and my ideas are listened to". Another said, "The best thing is the way they [management team] care about the residents, nothing is too much trouble, the management are really approachable".

The registered manager was open and transparent throughout our inspection, making sure they were available throughout the day to answer any questions we had, and providing us with necessary documentation. They kept their knowledge up to date by subscribing to trade magazines which highlight future legislation and current good practice schemes. They also visited the CQC website to keep up to date with care practice, and attended the local infection control group where they were able to network with other providers. Health professionals were also invited to team meetings to discuss best practice ideas. The management team need to ensure that any learning is transferred into the service for the benefit of people.

The registered manager, provider, and staff were clear about the aims and visions of the service. The service was expanding and the provider told us how they wanted to create a "Care Village" which incorporated residential and independent living on one site. The provider told us of their commitment to ensure high standards of care going forward.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The service did not make sure that all care records included reference to the social and emotional needs of people. Activity provision was not sufficient to meet everyone's needs.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality assurance systems did not identify where quality and safety were being compromised. Action was not taken to mitigate risks associated with staffing levels.</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there were sufficient numbers of staff with the skills and knowledge to meet people's care and welfare needs.

The enforcement action we took:

Warning Notice