

Crown Care IV Limited

Kensington

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The inspection took place on 16 and 19 December 2016 and the first day was unannounced. This was the first inspection of Kensington following a change in registration in February 2016 relating to the provider's brand.

Kensington is a care home that provides nursing and personal care for up to 41 mainly older people, including people who have dementia-related conditions. At the time of our inspection there were 31 people living at the home.

The service had a 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.

We found the service had established systems for protecting people from abuse and responding to any safeguarding concerns. Risks were assessed and measures were taken to prevent avoidable harm. The home was clean, comfortable and equipped to meet people's needs. Regular safety checks were carried out to ensure that care was provided in an appropriately safe environment.

New staff were suitably checked and vetted before they were employed. There were sufficient numbers of staff to provide people with continuity of care and support the running of the home. Staff were given training and support that enabled them to meet people's needs effectively.

People were supported to access healthcare services and maintain their health and well-being. Medicines arrangements were monitored to ensure they were fully robust. Specialist advice was sought when necessary to meet people's nutritional needs. Further improvements were being made to enhance the menus and mealtimes.

The service worked within the principles of mental capacity law to make sure people's rights and freedoms were respected. People and their relatives were involved in decision-making and supported to direct their care.

Complaints were taken seriously by the service and acted on. People told us they were confident in raising any concerns and felt they would be promptly addressed.

People and their relatives were mostly happy with the service and the caring approach of staff. However, we were told about and observed instances when people were not always treated with respect and their dignity was compromised.

Care plans were detailed, personalised to the individual and were adapted if their needs changed. Reviews

were held, giving people and their representatives the opportunity to discuss and agree how their care was given. There was a social activities programme in place and people were encouraged to pursue their own hobbies and interests.

The manager, although only recently registered, was an experienced nurse with good leadership skills and was held in high esteem by people living in the home, relatives and staff. The registered manager supported staff, promoted transparent communication and was committed to improving the service.

The service was open to suggestions and regularly asked people for their feedback. The quality of the service was routinely checked and audited. We have recommended this is further developed by closer monitoring of people's care experiences.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to dignity and respect. 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?

Good ●

The service was safe.

Appropriate steps were taken to safeguard people from harm and abuse.

There were enough staff to safely meet people's needs.

Risks associated with people's care were assessed and managed.

Arrangements were made to ensure people received their medicines at the times they required them.

Is the service effective?

Good ●

The service was effective.

Staff had the skills and knowledge to meet people's needs effectively. They were given regular training and supervision to support them in their work.

People's rights under mental capacity law were understood and respected.

People accessed a range of health care services and were given the necessary support to meet their health and nutritional needs.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Although many staff were caring in their approach, people were not always given care in a dignified way.

People and their families told us they were mostly happy with care and their relationships with staff.

People were supported to make choices and decisions about their care.

Is the service responsive?

Good ●

The service was responsive.

Care planning was tailored to people's individual needs and preferences.

People were given opportunities to engage in activities to help meet their social needs.

Any complaints raised were investigated and acted on.

Is the service well-led?

The service was not consistently well-led.

Systems to monitor the quality of the service needed some further improvement by keeping checks on care practice standards.

Staff were provided with good leadership and support.

There was an open culture and the management were committed to working inclusively with people and their representatives.

Requires Improvement ●

Kensington

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.

The inspection took place on 16 and 19 December 2016. The inspection was carried out by one adult social care inspector 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 the inspection we reviewed the information we held about the service. This included 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. We contacted the local authority commissioners and safeguarding team.

During the inspection we talked with 10 people living at the home and three relatives. We spoke with the registered manager, the managing director and eight nursing, care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at four people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Is the service safe?

Our findings

The people we talked with felt secure living at the home. Their comments included, "It's very safe here. They all look after me very well", "Yes, I'm quite safe and happy here. I'd rather be at home but I know I can't manage so this is the next best thing" and "It's a canny home and the staff treat me well." Relatives also told us they felt their family members were cared for safely.

Steps were taken to safeguard people against the risk of abuse and respond to any safeguarding concerns. Information was provided in the guide to the service that informed people and their representatives about their rights to be protected from harm and abuse. All staff were trained in and had access to safeguarding and whistleblowing (exposing poor practice) procedures. The registered manager and staff understood their safeguarding responsibilities and had taken appropriate action when concerns were received. This had included notifying the relevant authorities and co-operating with investigations.

Proper accounts were kept of cash held on behalf of people for safekeeping. Records were made of all transactions and receipts were obtained for purchases and services such as hairdressing. Audits were completed to check that people's money was being handled safely.

Suitable pre-employment checks were carried out when new staff were being recruited. Proof of identity, application forms and references, including one from the last employer, were sought and applicants were interviewed. Disclosure and Barring Service (DBS) checks were conducted. A DBS check supports safe recruitment decisions by providing information to employers about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. Checks were maintained of the qualified nurses' registrations to practice.

Staffing was determined each week according to the numbers of people living at the home and their levels of dependency. The staffing model tool used took into consideration the extent of support each person required and the risk factors involved in providing their care. The registered manager said they found this tool beneficial in calculating the staffing needed. They gave an example of a recent increase in day time care staff that had been readily authorised by the managing director. Extra nursing hours were also being introduced in line with new admissions of people with nursing needs.

At the time of our inspection, staffing was one nurse, one senior care and five care workers during the day and one nurse, one senior care and two care workers at night. One person received dedicated one-to-one support throughout the day to ensure their needs were safely met. The home was using external agency nurses, a bank nurse and bank care workers to meet staffing levels whilst new staff were being recruited. Existing staff also provided cover for absence when necessary. The registered manager was a qualified nurse and their working hours were in addition to the staffing levels. The clinical lead also had a proportion of supernumerary hours. The home had its own activities co-ordinator, maintenance person and an administrator. Catering, housekeeping and laundry staff were shared between the service and another of the provider's care homes on the same site.

During our visits we did not observe any instances of people's care being unsafe. Safety precautions, such as pressure mats, were used to alert staff to a person's movements if they were at risk of falling. Staff were visible throughout the home, supervising in communal areas and checking on people in their bedrooms. A relative commented, "Sometimes they seem a bit short of staff. I think they could spend a little more time stimulating residents with activities but [family member] is quite safe here."

Staff were able to get advice or support through the on-call system that was operated outside of office hours. This was a tiered system which meant any emergencies could be escalated to senior management. A business continuity plan was also in place for continuing to operate the service in emergency situations, including in the event of the home needing to be evacuated.

Risks to personal safety had been assessed and measures to reduce risks were built into care plans, giving staff guidance on how to safely support people. These addressed areas of vulnerability such as moving and handling, risk of falls, nutrition and maintaining skin integrity. Accidents and incidents were suitably reported, followed up and analysed. Actions to help prevent accidents reoccurring were taken, including updating risk assessments, implementing closer supervision and providing safety aids. Referrals were also made to other professionals, for example, for GPs to review medicines and to a specialist falls clinic for input.

We observed the home was clean, comfortable and suitably maintained. Housekeeping staff worked to cleaning schedules, had lockable trollies for holding cleaning chemicals, and confirmed they had received COSHH (Control of Substances Hazardous to Health) training. Supplies of personal protective equipment were provided for staff use. All staff were trained in safe systems of work and guided by the provider's safety-related policies, procedures and risk assessments.

Servicing agreements were arranged for tests and checks of the home's facilities and equipment. The service was able to call upon the provider's estates team and external contractors to carry out works. Recent works had included making adjustments to water pressure and attending to a fault on the passenger lift keypad. Monthly safety inspections of the building were carried out by the maintenance person who checked equipment, any repairs needed, fire safety, and any safety or health hazards requiring attention. Further safety checks and audits were carried out at regular intervals. Company documentation was being introduced to ensure clearer evidence was provided of the frequency of checks and any necessary remedial action taken.

Prescribed medicines were ordered monthly and kept securely stored, including monitoring temperatures of the treatment room and drugs fridge. Staff responsible for administering medicines had received appropriate training and had their competency assessed. Sufficient information was available to staff about people's individual medicines routines. This included care plans, profiles with the person's preferred method of taking medicines, and details of any allergies. For example, one person's profile stated '[Name] likes to take her medication from a spoon, one at a time'. The people we talked with told us they received their medicines on time and that staff stayed with them whilst they took their medicines. One person told us, "Even if you have a headache they will offer you something."

Medicines were audited weekly and a full audit of the medicines arrangements had been carried out by the managing director at the beginning of December 2016. The registered manager showed us they had acted on the areas highlighted for improvement. This had included updating protocols for medicines given on an 'as required' basis, investigating missing signatures, and reinforcing good practice with the nurses and senior care staff. We identified some further recording issues in the medicine administration records which we raised with the management and were given assurance of immediate follow up with the staff member

responsible.

Is the service effective?

Our findings

People and their relatives described the care as being effective. Their comments included, "I'm very happy with how they look after me and I do what I can for myself", "I think they're all marvellous. You can't fault the care" and "The staff have the skills my Mum needs. She is settled, well-fed and they prompt her to drink. She can walk, but they assist her."

New staff were given an in-house and company induction to help prepare them for their caring roles. They then went on to complete the Care Certificate, a standardised approach to training for new staff working in health and social care. We saw that staff received copies of the provider's key policies, such as whistleblowing, confidentiality and health and safety at work, which they verified they had read and understood. A revised staff handbook had also been issued in recent months. This informed staff of policies and procedures, conditions of employment, and the standards and code of conduct expected of them.

A training matrix was maintained that gave an overview of all the courses the staff team had completed. This showed that mandatory training in topics such as moving and handling, fire safety, infection control, first aid, and health and safety was up to date. A range of other training had also been undertaken in relation to people's needs. This included understanding dementia, challenging behaviour, safe use of bedrails, equality and diversity and end of life care. Advanced training was provided for staff who had lead roles for different aspects of care. Most of the care staff, including seniors, had also achieved nationally recognised care qualifications.

Regular reports were run to keep checks on training and that staff were being provided with supervision at regular intervals. We saw that individual supervisions and annual appraisals were mainly on course to meet the standards set by the provider. The registered manager explained they had organised dates for those supervisions and appraisals which had lapsed due to the absence of one of supervisors.

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 found that the service worked within the principles of the MCA. Most staff had been provided with MCA and DoLS training to help them understand the implications for their practice. People had care plans around their rights and abilities to give consent to their care, including where the person had fluctuating capacity. A relative confirmed to us they were an appointed power of attorney for their family member and were involved in decision-making about their care.

The registered manager told us they firmly believed in upholding people's rights to make their own decisions. They gave us an example of a mental capacity assessment being carried out with a person who was refusing their medicines. This had established the person was capable of making such decisions and staff were working with them and their GP to resolve the issue. Formal processes had also been followed to have DoLS authorised for many of the people living at the home to enable them to receive the care and treatment they required.

Care records showed that people's nutritional needs and risks had been assessed and care planned. For example, one person had a care plan that addressed their need for a soft textured diet, prompting and supervision with meals due to a risk of choking, and the provision of prescribed nutritional supplements. We saw this regime was working well and the person was gaining weight.

People's weights and, where necessary, food and fluid intake were monitored. Dietetic advice was sought when needed and the majority of staff had received training in nutrition awareness. Information about people's dietary requirements was held in the kitchen. The chef told us special diets were catered for and food was routinely fortified to add calorific content.

People gave us variable comments about the food provided. They told us, "The day revolves around food", "There's always plenty of food. They used to give me too much on the plate and it put me off eating, so now I just get small portions. If I don't fancy what they've got I can have a sandwich or an omelette", "The food's not been very good. It's been repetitive but there's a new chef so I'm hoping things will get better" and "The food is not the best, but there's enough of it. I usually have soup and a sandwich and they're always coming round with cups of tea and a biscuit"

During our visit the management held a planned meeting with the kitchen staff, including the newly appointed chef, to discuss the catering arrangements. The managing director told us the numbers of kitchen staff on shift each day were being increased to ensure adequate capacity for catering across the two homes. Further duties had been allocated to kitchen staff including making sure the day's menu was displayed, stocking the small kitchens on each floor and assisting with serving meals. Mealtimes were also starting to be staggered with a view to supporting those people who needed assistance with eating and drinking at the first sitting. We noted the current menus gave no indication of suppers or snacks between meals and that sandwiches regularly formed part of lighter meals served for lunch. The management assured us these matters would be reviewed during the introduction of the new winter menus.

People we talked with told us they felt their health needs were being met. One person commented, "The chiropodist comes in to do my feet." Another person explained that staff accompanied them to hospital appointments when their relatives were unable to do so. A relative told us their family member's illness was progressing and they had been involved in a useful session with staff that was led by a specialist behaviour team.

People were supported to access a full range of health care services and the home was taking part in a local care home project that aimed to prevent avoidable admissions to hospital. We saw information was gathered that informed staff about each person's medical history and their current physical and mental health conditions. Health care needs were detailed in care plans and all contact with, and advice about treatment, from external professionals were recorded. Emergency health care plans and decisions about resuscitation were also documented to ensure people's wishes for their future care were adhered to.

Is the service caring?

Our findings

People spoke positively about the caring approach of the staff. They told us, "They're ever so caring and helpful and will always have a word when they pass the door", "The staff here are lovely. They're more than staff, they've become like family", "You always get good and bad wherever you go but they're pretty good here. They know how to care for you. There's been a few changes recently and it's been a bit unsettling but it's getting sorted now", "Staff are very, very good, very helpful and very caring", "I'm safe, comfortable and happy, what more can you ask for?" and "The staff are grand."

The atmosphere in the home felt calm and welcoming. Routines were flexible and we saw staff respected the choices people made. People confirmed they could get up and go to bed at the times they wanted and chose where they spent their time and took their meals. Where people were unable to tell us about their care, we saw they looked relaxed in the company of staff and responded well when they interacted with them. People who were nursed in bed appeared comfortable and well cared for.

Most of the people and relatives we talked with told us staff were accommodating and provided a good standard of personal care. Their comments included, "Mum is always clean with co-ordinated clothes", "The staff are all helpful and will get things for me and sort my laundry. I don't like baths or showers so they give me a regular wash down as that's what I like" and "The staff here help you in any way they can. They look after me really well. If I want a shower I can have it and if I want a bath I can have one. Nothing is too much trouble." One relative told us their family member's care was provided only by female staff and commented, "I think they could pay more attention to detail."

The staff we spoke with had good knowledge of the needs of the people they supported. We observed most staff had a good rapport with people, engaged with them in a meaningful way and showed compassion. We saw staff explaining what they were doing, talking through the stages when giving support, and offered people encouragement and reassurance. For example, a staff member walked alongside a person, gently guiding them to where they wanted to be. They were patient with the person, talking with them as they went along at an unhurried pace. On another occasion we heard the registered manager on the telephone to a relative. They acknowledged their feelings, spoke in a caring manner and reassured them that the GP had been contacted to visit their family member.

However, we were informed about and observed times when people's care was not given in a caring or dignified way. One person described needing more timely support from staff with their toileting needs at a particular time of day. A relative told us at times they had found their family member lying on the bed with their clothes or nightwear not fully covering their body. The relative explained they had bought quilts and throws which staff did not consistently use to cover the person and keep them comfortable.

During lunch we saw a staff member sat with a person who was unable to eat independently. They did not speak to the person throughout the meal or take care when giving them food. This resulted in food being smeared around the person's mouth and being spilt onto the plastic apron they were wearing. When the person had finished eating, the staff member proceeded to wipe their mouth and then the mouth of another

person at the table, again without any interaction or explanation. At the end of the meal as people were leaving the dining room we noted another staff member stood over a person, giving them soup that must have been cold by that time. We concluded that people were not always being treated with dignity and respect.

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

Care records were held electronically and training had been provided for staff in data protection and confidentiality. The computer system was password protected and we observed staff were mindful of being discreet when accessing and talking about people's personal details.

A range of information was provided and displayed for reference about the service's ethos and what people could expect from living at the home. This included an informative guide to the service, a 'resident charter', details of social activities and events, and a noticeboard dedicated to dignity in care. The management's response to quality surveys were on display, informing people and their representatives about the ways their comments had influenced the service. Leaflets about care-related topics and other care services were also made available.

We saw that people and their relatives were supported to express their views about the care provided and the service in general. They were involved in reviews of care and could give their feedback through meetings and surveys. The registered manager told us they could arrange for advocacy services if any person needed an independent representative to act on their behalf.

Is the service responsive?

Our findings

We observed there were no undue delays in people being attended to and staff were responsive to needs and requests. One person said, "The staff are always around when I need any help." Some people told us they knew how to summon help by using the call bell and all but one said that help was quick or fairly quick in coming. Our observations confirmed that staff responded to call bells in a timely manner.

Relatives said they could visit at any time, were made to feel welcome and were kept informed of significant events. One visitor commented, "The family are very happy with the care and the staff are nice, very friendly and down to earth." Another visitor said, "They (staff) contacted me when my relative had a fall." Relatives confirmed they were able to have continued involvement in their family members care. A relative told us, "I've been involved in Mum's care plan and we review it three monthly, I think."

Care records showed people's needs had been assessed before admission to the home to ensure they could be met. A range of assessments were then regularly completed to determine people's current needs, risks associated with their care and dependency level. This information was used to develop individual care plans which we saw were detailed, personalised and reflected all identified needs. The care plans guided staff on the extent of care the person required and the ways they preferred to be supported.

Care plans were evaluated each month and updated when people's needs had changed. There was evidence that annual reviews had been held to consult with people and their families and agree the care provided. Dates of review meetings for people who had moved into the home in recent months were forward planned.

Staff reported on each person's well-being and significant information was relayed at handovers between shift changes. This enabled staff to be kept up to date and informed about any changes or incidents affecting people's welfare.

People told us there were activities available to them and that they had choices in how they spent their day. Several people said they preferred not to join in with the activities programme. Most people we talked with told us they did not have any particular hobbies or interests, but those who did said they were supported by staff. One person told us, "I've crocheted things for years and although I'm stuck in bed I still crochet every day and the girls make sure I've got everything next to me so I can reach the wool or a drink." Another person said they liked the visits from the 'sweet lady', who brought old-fashioned confectionery into the home for people to buy. They told us, "I've got a drawer full of sweets."

One relative felt there could be more emphasis on individual stimulation. They commented, "It would be nice if there was some spiritual activity. My relative used to go to church and it was a focus for her and she misses it now." This relative also said, "The TV is always on and I think that sometimes it would be nice to have some old time music on. My relative can't see so she would enjoy music." The co-ordinator told us they had started to audit and review activities, were open to suggestions for improvements and were planning to do more activities on a one-to-one basis.

We saw people had social care plans that included their interests and contact with family and friends. The home's activities co-ordinator arranged a weekly programme of activities and recorded people's participation. We observed this had recently included reminiscence, a movie afternoon, quiz, a visit from a local choir and a weekly book club. The co-ordinator told us they also organised outings, visiting entertainers and celebrated events such as cancer charity coffee morning and World Mental Health Day. They had access to a range of resources to utilise and said they received good support from other staff including ideas for fundraising. During our visits activities took place including reading newspapers with people, playing bingo, a Christmas party and a pantomime.

People and their relatives were generally satisfied with how complaints and concerns were dealt with. One person commented, "I'm quite happy with things here, there's nothing to complain about." A relative said, "If I have a concern, I just mention it and it gets sorted."

We reviewed the complaints log and found that those made during 2016 had been responded to and investigated. Most appeared to have been resolved to the satisfaction of the complainants, though at times this was difficult to establish from the complaints records. The registered manager told us about the actions taken in response and said they would ensure a clearer audit trail was kept. A number of cards and letters thanking and praising the service had been received and records of compliments were maintained.

Is the service well-led?

Our findings

The manager had become registered with the Care Quality Commission (CQC) in November 2016, though had worked in the home for periods of time since 2013. They were aware of the requirements of their registration, including notifying CQC of events affecting the service.

We observed the registered manager had a visible presence and knew the people living at the home and their families. People and their relatives were positive about and had confidence in the management of the home. One relative told us, "I can see a real difference now for the better, in the building, the staffing and the management."

Staff also spoke highly of the registered manager and the support and leadership they received. Their comments included, "[Manager] is very good. She goes out of her way to get to know and spend time with the residents. She gets her messages across firmly to us about the standards she expects", "The manager is lovely and on the ball", "The manager is fair and runs a tight ship" and "We get plenty of support and supervision."

The service had a policy on the 'duty of candour'. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. The registered manager told us they were committed to working inclusively with people and their families and ensuring lessons were learned from incidents, complaints and safeguarding concerns. This was confirmed by a relative who told us a serious concern they had raised had been managed through the safeguarding process. They said, "I'd lost faith, but things are much better now."

The registered manager told us they had been doing daily 'walkarounds' which had now been replaced by 'flash meetings' with different grades of staff. The meetings were structured to ensure they were kept apprised of people's clinical and care needs, appointments with professionals and any concerns, accidents or incidents. They also reviewed any issues relating to maintenance, catering, social activities and housekeeping. Bi-monthly staff meetings were held where we saw a range of practice and employment topics were debated. New and revised policies and procedures had been introduced and there were plans to cascade these to staff by having a 'policy of the month' theme.

Systems were in place for involving people and their relatives in the running of the home. Resident and relative meetings were held every three months and the registered manager was exploring ways to improve attendance. Monthly newsletters were produced and distributed with information about the service. People and their relatives were asked to complete surveys to assess their levels of satisfaction with the service. Completed surveys were returned to the provider's head office for analysis before being sent onto the home. The latest survey results and what the management had done in response were displayed. One person told us, "I've been asked for feedback and I've given good feedback." Surveys with stakeholders were also planned to be carried out.

The managing director was taking a lead role in inducting, supervising and supporting the registered

manager. They had recently completed a full quality audit of the service, with an action plan for areas of improvement that we saw the registered manager was in the process of completing. The managing director was visiting again to check on the progress before handing back line management responsibilities to the home's regional manager.

A range of internal audits were also conducted each month to check the quality of the service. These covered areas such as care records, specific areas of care such as weight loss and pressure damage, medicines, the kitchen and infection control. Audits were being adapted to ensure all had action plans which would feed directly into the senior management overall quality assessment of the service.

The management acknowledged our inspection findings about people not always being treated with dignity and respect. They took on board that further efforts needed to be built into the quality assurance system to check the ways that people's care was being delivered. The registered manager told us they were also looking to designate a new 'dignity champion' who would lead on promoting dignified and respectful care.

We recommend that the provider improves governance arrangements to ensure care practices and people's care experiences are more closely monitored.

The managing director and registered manager described their plans for the future development of the service. They intended to review the roles, accountability and deployment of certain staff, continue to improve the environment and have quarterly meetings with the provider's new health and safety advisor. Further benefits planned for people living at the home included increasing the activities co-ordinator hours and rolling out 'resident of the day'. This is an initiative whereby staff of all grades are given time to get to know each person and personalise their care according to what is important to the individual.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that people using the service were treated with dignity and respect at all times.