The Elms Residential Home Limited

The Elms Care Centre

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Elms Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to accommodate 18 older people some living with dementia and mental health difficulties; at the time of our inspection, there were 17 people living in the home.

At our last inspection in September 2016, this service was rated overall as good. At this inspection, we found that the service had deteriorated and has been rated as requires improvement. This is the third time the service has been rated as requires improvement in the last three years.

The inspection took place on the 31 July and 6 August 2018 and was unannounced.

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. The registered manager was absent at the time of the inspection and the service was being managed by a newly appointed deputy manager, supported by the provider.

There was not always sufficient staff with the right skills deployed to meet everyone's needs. People's access to activities in and outside of the home was limited.

The home was not well maintained and access to the garden was limited due to the poor maintenance of the paths. Areas of the home needed redecoration and refurbishment. We have made a recommendation about the access to the garden.

Care plans were basic and lacked the detail to support staff to provide person-centred care. However, the provider was aware of this and was in the process of introducing new care plans which were person-centred and would contain the detail staff needed to provide consistent care and support.

The systems in place to monitor the quality of care and effectiveness of the service had not been consistently maintained. Audits had not been regularly undertaken so any shortfalls had not been identified. The provider was working with the local authority to address this.

People were supported to have choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People's health care and nutritional needs were considered and relevant health care professionals were appropriately involved in people's care.

People received care from staff that knew them and were kind, compassionate and respectful. The staff were friendly, caring and passionate about the care and support they delivered. However, people's dignity was not always protected.

Staff were appropriately recruited. People received their prescribed medicines safely. Staff understood their responsibilities to keep people safe from any risk or harm and knew how to respond if they had any concerns.

Staff had access to the support, supervision and training that they required. However, induction training for new staff needed to be improved and access to specialist training would be of benefit.

The service had a positive ethos and an open culture. People knew how to raise a concern or make a complaint and the provider had implemented effective systems to manage any complaints that they may receive.

At this inspection, we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end 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.

There was not sufficient staff with the right skills deployed to provide the care and support people needed.

Environmental health and safety audits had not identified shortfalls in the overall cleanliness and maintenance of the home and outside area.

There were safe systems in place for the administration of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People could not always be assured that they were being cared for by staff who had the right skills and knowledge to support them.

People had not always had access to a healthy balanced diet and their health care needs had not always been consistently monitored. However, improvements were being made following support from the local authority.

People were involved in decisions about the way their support was delivered; staff understood their roles and responsibilities in relation to assessing people's capacity to make decisions about their care.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans provided basic information and needed to be developed to provide more detailed information to enable staff to provide person-centred care

Staff did not always maintain people's dignity.

Positive relationships had developed between people and staff.

People were treated with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed before they came to stay at the home but there were inconsistencies in the level of information captured to ensure that staff had all the information they needed to support people.

There was limited opportunity for people to pursue their interests and take part in activities.

People were confident that they could raise a concern about their care and there was information provided on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led

The systems in place to monitor the standard and quality of the service had not been maintained and any shortfalls had not been identified.

People did not always have the opportunity to give their feedback.

The provider sought advice and support and was receptive to ideas as to how the service could be improved.

The Elms Care Centre

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 July and 6 August 2018 and was unannounced. It was undertaken by one 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. In this instance, our expert-by-experience had cared for a relative.

We brought forward a planned inspection following concerns raised by the Local Authority and a member of the public about insufficient staff deployed, the general cleanliness of the home and the management support within the home. These concerns informed our inspection.

Before the inspection we reviewed information that we held about the service such as notifications, which are events that happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection, we spent time observing people to help us understand the experience of people who could not talk with us. We spoke with seven people who used the service and eight members of staff, which included two senior care assistants, three care assistants, a domestic, a maintenance person, a cook and the deputy manager, plus a care executive assistant who supported the provider. The registered manager was unavailable. We also spoke with five visitors to the home which included two relatives, a friend of one person and two health professionals.

We looked at the care records of three people to see whether they reflected the care given and three staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, infection control policy and procedures, training information for care staff, minutes of meetings with staff and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2016 'safe' was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

Concerns about there not being enough staff deployed in the home had been raised with the Care Quality Commission (CQC) prior to our inspection, we took this into consideration during our inspection.

There were not enough staff deployed to meet people's needs in a safe and timely way. On the first day of the inspection there were 17 people living in the home being supported by one senior care assistant and two care assistants throughout the day and one senior care assistant and a care assistant at night. The ground floor of the home had both communal areas, bedrooms and bathrooms and on the first floor there were bedrooms and a bathroom. There were at least four people who required assistance from two care staff and one person who needed to be observed and supervised due to their mental health and safety. This meant that there were times during the day that people were left waiting for support and unsupervised, which put them at potential risk.

In addition to providing basic care, the care staff were also expected to complete other duties. For example, the night staff had to clean the kitchen and care staff were expected to provide activities for people.

People told us that they did not feel there was enough staff. One person said, "I do not feel that there is enough staff." Another person said, "I have to wait sometimes when I press my buzzer, it depends on who is on and how busy they are." A relative said, "It would be nice if people could spend time in the garden but there is not enough staff to help people."

We observed that several people remained seated in the same place throughout the day, only being assisted if they required the toilet or wanted to sit at the table for meals. This could potentially put people at risk of a break down in their skin integrity. There was very little interaction with people outside providing basic care, with no real stimulation offered to them except the Television being left on. We saw that only one person accessed the garden when the deputy manager and care executive assistant supported them.

Following a visit in June 2018 by the local authority commissioning team, the provider had started to use a system to assess the number of basic care hours people needed to calculate the number of care staff required. However, this did not consider the level of observation and supervision people needed nor the lay out of the building. Although most people spent their time in the communal areas, some people preferred to stay in their bedrooms, the majority of which were upstairs. This meant that at times, people were left unattended and at unnecessary risk.

There had been an incident in April when a person living with dementia had left the premises around 6am, unnoticed and fell. Although the provider had added additional security to the doors and staff were instructed to ensure that there was always a member of staff on the ground floor there was no consideration given as to whether there should be any additional staff.

The provider had failed to ensure that there were sufficient numbers of staff deployed to meet the needs of people in a timely and person-centred way. This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental health and safety audits had been undertaken, however, they had failed to pick up and address the uneven paving and access to the garden. The garden had been maintained to a certain degree however, no one could access it independently and even with assistance people would be limited to where they could safely go. We recommend that the service reviews the arrangements for people to access the garden.

The overall general cleanliness and maintenance of the home needed to be improved. We saw several stained carpets and bathroom equipment such as a bath chair were not cleaned to a good standard. One relative told us they had found their loved-one's room dirty on several occasions, they had spent time cleaning it themselves. The deputy manager advised us there had been an issue about the cleaning of the room and had implemented a schedule for cleaning for the domestic staff to follow. We saw that they were proactive in monitoring the schedule and addressing any shortfalls with the staff. However, this was a new initiative which we were unable to fully assess its effectiveness.

The provider needed to ensure that there were sufficient resources deployed to maintain the cleanliness and general maintenance of the home. We saw that several armchairs were stained and worn and some carpets were stained. We pointed out the armchairs to the provider who agreed to replace them and we saw that a carpet was being replaced in one of the bedrooms. The provider needed to ensure that there was a planned programme of refurbishment in place.

Prior to the inspection the CQC had been notified by the provider that there had been an unconfirmed outbreak of scabies, and had also received information from a member of the public raising their concern that people had not been made aware of the outbreak. We checked what action the provider had taken and were satisfied that the provider had sought appropriate advice and followed the guidance given.

The home had been closed for three days and families informed. Although there had been no confirmation of scabies all people and staff had been treated.

We saw staff wearing protective clothing when required to and these were disposed of appropriately. There were procedures in place for the prevention and control of infection and staff had received training.

People looked relaxed and comfortable in the presence of the staff. People told us they felt safe in the home. One person said, "I feel safe as they come and check up on us in the night."

Not all staff understood their roles and responsibilities in relation to keeping people safe or knew how to report concerns if they had any outside of the home. Although staff told us they had received training in safeguarding and records confirmed this, the provider needed to ensure that all staff understood their responsibilities. There was an up to date policy and procedure. The provider had not been contacting the local safeguarding team when any concerns had been raised nor notifying CQC as required. However, following the visit from the local authority this had been raised and since then notifications had been made.

There were a range of individual risk assessments in place to identify areas where people may need additional support to manage their safety. For example, people identified as being at risk of damage to their skin due to pressure or who were at nutritional risk had been assessed; appropriate controls had been put in

place to reduce and manage the risks. Records showed that the care specified had been provided for example people were supported to change their position regularly and had their food and fluid intake monitored to ensure their well-being. However, the information recorded for each person was not always complete, for example records relating to people's fluid intake had no goals identified as to how much a person needed to remain safely hydrated and the information had not always been collated, which potentially left people at risk.

People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. All staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they started work at the home.

Following a monitoring visit from the local authority shortfalls had been highlighted in the administration of medicines to people. We saw that the provider had acted to address the shortfalls. There were now regular audits in place to ensure if there were any discrepancies these could be quickly addressed. We saw that people received their medicines at regular times and we observed people being given their medicines. Staff explained what the person was taking and ensured they had sufficient fluid to take them with; they stayed with the person and ensured that they had taken their medicines. Staff had received training and the provider was in the process of testing their competency. One person told us, "They never forget to give me my medication and they make sure that I take it."

Accident and incidents were recorded and there was a new system in place to collate and send the information each month for the provider to analyse. We saw that this had only been implemented in June so we were unable to fully assess how effective this was. The local authority was carrying out regular visits to monitor the progress the provider was making in relation to concerns they had raised.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in September 2016 'effective' was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

People could not always be assured that they were being cared for by staff who had the knowledge and skills to support them. Induction for new staff needed to be improved. In our conversations with staff it was clear that they had not all completed the full training they required, nor undertaken any specialist training to equip them to manage people's behaviour which may become challenging. We observed that when a person had become agitated and distressed, a care staff member did not know what to do and walked away from the situation, another member of staff managed to distract the person and calmed the situation down.

We were made aware that staff training was being revised and up dated and information was shared with us about training that was being planned. The provider needed to ensure that the induction training for new staff was thorough and that the new staff had fully understood the training and their competencies tested before they were left to work unsupervised.

Staff had supervision but there was some inconsistency around the level of frequency of supervision meetings. We saw that the new deputy manager had updated the supervision schedule and was in the process of ensuring that all staff had regular supervisions and appraisals.

People were assessed before they came to stay at The Elms Care Centre. Care plans were developed which gave some guidance and information for staff to follow. We saw that the care plans were being reviewed and redesigned following concerns raised by the local authority. This would benefit people as more detailed and up to date information would support staff to provide person-centred care. A relative told us, "I know of [name of relative] care plan, I know what is in it and had some of it changed."

People had not always been supported to maintain a healthy balanced diet and those at risk of not eating and drinking enough had not been always identified in a timely way. A number of people had lost weight but the provider had been slow to act. Following concerns raised by the local authority referrals had been made to the dietitian and speech and language therapist. We saw that the provider had put systems in place to improve the monitoring of people's nutritional intake. The kitchen staff were informed of people's specific dietary needs. However, the provider needed to ensure that staff were completing records fully so the information was accurate and appropriate action was taken in a timely way. A relative expressed their concerns that they did not feel that those people who needed support to maintain good nutrition always got the support they needed.

There was a choice of meals and if people did not want what was on offer they could be given an alternative. However, the level of food stock was minimal which meant there was not always the food available people wanted.

People told us that since the new cook had started the food had improved. One person said, "The food is

okay, we have a choice of two." Another person said, "I can have a cooked breakfast if I want one."

We spent time observing meal times. There was not sufficient space for everyone to sit at the table if they wished. A few people remained in the lounge area with lap tables. There was very little interaction between staff and people outside the task of serving the food. Meals were already plated and people had to ask for condiments. People were not rushed but there were delays in getting food out to people. There was little space for staff to support those people who needed assistance. We saw one member of staff kneeling next to someone to assist them.

The provider needed to look at ways to improve the dining experience for people and ensure that people were properly supported. We also saw that some people had not finished their breakfast until 10.45am and lunch was served between 12 and 12.30. The provider needed to ensure that there was a sufficient interval between meals for people to digest their meal and be ready for the next one.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

The manager and senior staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. Applications had been made to seek authorisation from the local authority who placed people who may lack the mental capacity to make decisions about their care and treatment. Some people were under constant supervision and were unable to access the community without support from staff. We saw that a review of people's restrictions was underway and new referrals were being made where needed.

People were encouraged to make decisions about their care and their day-to-day routines and preferences. We observed people freely moving around the home and spending time in different communal areas and in their bedrooms, however, there was no safe access to the garden so people were unable to go outside if they wished to. We observed one person who was determined to go outside. Staff initially tried to distract the person but eventually the deputy manager supported them to go out into the garden. The provider needed to ensure that the garden was secure and easily accessible for people to enjoy.

District nurses visited daily when required and a senior nurse practitioner visited regularly. We spoke to two health professionals who were visiting at the time of the inspection. Both felt the staff were proactive if they had any concerns about people's health. One person told us, "We see the GP if we need to, not sure about seeing an optician or dentist." A relative expressed their view that perhaps the staff were not as proactive enough if people became unwell. During the inspection a person did become unwell and the staff responded by calling the paramedics and the person was taken to hospital.

The home was not purpose built so adaptations had been made to it. The décor was tired and some of the furnishings needed replacing. We saw that the provider had recently undertaken an audit and identified areas requiring improvement. However, action to put things right seemed to be slow and people were left in an environment which needed to be improved.

There was a nice garden people could look out onto but no access for people. In the conservatory area where people ate their meals there were no blinds on the windows. At the time of the inspection the weather was very hot and people would have benefitted from being shaded from the sun whilst they ate.

Although, the home did not provide specialist care for people living with dementia it would have been helpful if more consideration was given to those people who were living with dementia to support them with their orientation around the home. The provider needed to ensure that a programme of refurbishment was in place and delivered in a timely way.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in September 2016 'caring' was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

We saw that people had developed positive relationships with staff and were treated with kindness and respect. However, the interactions with people were task focussed. The staff had very little time to spend with people outside supporting them with their care needs. One person said, "The staff don't sit and talk to you."

Care plans contained basic information to inform staff of people's likes and dislikes, their preferences as to how they wished to be cared for and their cultural and spiritual needs. However, they were not very detailed and it was not clear how much people and their families had contributed to them. A relative commented that their loved one had told them that they did not feel they were washed properly and that they now only had a shower twice a week when they had preferred to have a shower each day. There was no information to suggest that this had been discussed with the person.

We saw that the provider was in the process of reviewing all care plans and saw an example of the new style care plans being put in place. These were more person-centred however, the provider needed to ensure that they were fully involving people and their relative if appropriate.

People's dignity was not always protected. We observed people using the bathroom with the door left open, staff had not noticed as no action was taken to ensure that the person's dignity was protected. One person had asked for assistance to go to the toilet and there was a delay in staff supporting them which led to the person soiling themselves. The provider needed to ensure that staff were more vigilant, be protective of people's dignity and deployed to assist people in a timely way.

Care records were not secured and daily records were kept in files which were left in the dining area. This meant that people's confidentiality could be compromised. We spoke to the deputy manager and they ensured that a lock was fitted on the cupboard were the care plans were kept before the end of the inspection. They were also looking at where else daily records could be kept more safely.

Families and friends were welcomed. However, there was no space for people to meet privately apart from their bedrooms. We saw that when people visited the staff did not have the time to offer to help people to their rooms, so people remained in the lounge areas with their visitors. One relative commented, it would be nice to be able to go outside in the garden but the staff are too busy to assist. The provider needed to consider how to enable people to meet privately with their family and friends.

There was a friendly and welcoming atmosphere around the home. People looked happy and relaxed. One person said, "The staff are great, they treat me lovely." Another said, "Most of the staff are caring and treat you with respect."

People's choices in relation to their daily routines were listened to and respected by staff. One person said, "I can get up and go to bed when I like." We also heard staff offering one person the opportunity to have a lay down and spend time in their room if they wished.

People had access to an advocate to support their rights to have choice, control of their care and be as independent as possible. The manager understood when people might need additional support from an advocate. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Requires Improvement

Is the service responsive?

Our findings

.At the last inspection in September 2016 'responsive' was rated as good. At this inspection 'responsive' has been rated as requires improvement as there were areas which had deteriorated.

People had care plans, however, these were not person-centred and lacked the detail to support staff in engaging with people in a meaningful way. For example, there was no information about people's past history, hobbies or interests.

There were inconsistencies in the level of information collated about people and some plans had not been updated to reflect the change in needs of people. For example, in one care plan we saw the a person required one person to support them however, we then read information that they needed to staff to support them. The care plan was not updated to reflect the change in dependency. However, following advice from the local authority the provider had started to revise the care plans and we saw that the new plans were person-centred and provided the information for the staff to respond to people in a more meaningful way. We were unable to assess how effective the new care plans were as they had yet to be embedded and sustained.

People were not always supported to follow their interests or undertake meaningful activities. The staff did not always have time outside of supporting people with their personal care to spend time with people. There were limited activities available to people and we observed people spending long periods of time during the day with nothing to do and no stimulation. At one point during the inspection two members of staff sang and danced with a couple of people for a few minutes, which people appeared to enjoy and appreciate and one person was given a book to look through to reminisce; but outside of this very little social interaction took place.

People did not have access to the garden which from our observations would have benefitted a couple of people who were at times quite restless and keen to go outside. One relative commented what a shame it was the people did not get out into garden to enjoy the fresh air. The relative's loved one had also commented it would be nice to spend time outside. One person told us, "I am not allowed into the garden, there is not enough staff to take us out."

This was a breach of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of the staff had worked at the home for several years and it was clear that they knew people and understood their needs. Staff spoke fondly of people.

At the time of the inspection, nobody was receiving end of life care. We saw that some staff had received training in end of life care but this was a few years ago. There was no information held in care plans as to whether people had been asked about their preferences in relation to end of life care. The provider needed to have procedures in place for managing end of life care and ensure that staff received the training and

support they needed.

If people were unhappy with the service, there was a complaints procedure in place, however the procedure needed to be updated to ensure it contained up to date contact details for people. People told us they would speak to the manager if they had any concerns. One person said, "I have no complaints, but would speak to someone if I did." We saw that when a complaint had been made the deputy manager had responded to it in a timely way and action taken to address the issue raised.

The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. At the time of the inspection the service was not supporting anyone with a sensory impairment and as such had not looked at how to make information accessible. The provider needed to review the information they had and ensure that it was accessible for people with disabilities and sensory impairment to comply with this requirement.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2016 'well-led' was rated as good. At this inspection 'well-led' has been rated as requires improvement as there were areas which had deteriorated.

The systems in place to monitor the quality and standard of care had not been consistently maintained and sustained. Audits had not been regularly undertaken which meant any shortfalls were not addressed. There had been a lack of oversight of monitoring food and fluid intake for people. Regular audits of care plans would have identified that information was not consistent and not always up to date.

Medicine audits had not been undertaken so that issues around the administration of medicines had not been identified until the local authority had completed their monitoring visit. This meant that people had been left at potential risk. We found that following advice from the local authority the provider had already started to address this. An action plan was in place and monitoring of the service had begun. As this had only just been implemented when we inspected we were unable to assess the effectiveness and sustainability of the systems.

The provider had failed to recognise that the care within the home was not person-centred and that staff were task focussed. They had expectations that staff would provide activities for people but had not taken this into account when deciding on the staffing levels.

Staff supervision was inconsistent and understanding around safeguarding procedures amongst staff varied. Staff induction training needed strengthening to ensure all staff were sufficiently skilled and equipped to support people.

The provider had failed to recognise the need to replace chairs until this was pointed out to them on inspection.

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

Notifications about certain events within the service, which the provider has a legal obligation to report had not always been consistently submitted. Following advice from the local authority the provider had acted and relevant notifications were being received.

The provider had identified that some aspects of the home needed refurbishing, however, there was no clear refurbishment plan in place. The garden was not accessible for people and there was a lack of space for people to meet with their families in private. We saw that in a survey completed in 2017 relatives had commented that the home lacked a private place for people to meet.

People's views and opinions were not always sought. People told us they had never been asked what they thought. There were no meetings for people and their families held which would enable them to have their

say and hear about the plans the provider may have to develop the home.

We saw that since the new deputy manager had been in post there were regular staff meetings and staff felt they were listened to. People spoke positively of the new deputy manager, one person said, "I find the manager approachable." There was a general feeling amongst people and staff that the new manager listened to them.

The atmosphere around the home was friendly and welcoming and the staff team worked well together. which led to an open and transparent culture.

There were procedures in place, which supported the staff to provide consistent care and support, Staff demonstrated their knowledge and understanding around such things as whistleblowing, safeguarding, equalities, diversity and human rights.

The provider liaised with the local authority who placed people at the home and was receptive to any advice and support offered to enhance the life experiences of people. Advice and support was sought from the local GP practice, senior nurse practitioner and other health professionals when required.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had displayed their rating at the service.

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 9 HSCA RA Regulations 2014 Person-centred care The care people received was task focused and not person-centred. People did not have access to activities which supported their individual interests and their preferences were not always considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and standard of the service had not been consistently maintained. Audits had not been regularly undertaken so that any shortfalls had not been addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The was not always sufficient enough staff with the right skills and knowledge deployed to care for people safely.