Orchard Care Homes.Com Limited

Lofthouse Grange and Lodge

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place over two days, 26 November 2014 and 3 December 2014. At the last inspection in August 2014 we found the provider was breaching regulation 9, care and welfare of people who used services. At this inspection we found the provider was still in breach of this regulation and was also in breach of regulation 12 cleanliness and infection control, regulation 10 assessing and monitoring the quality of service provision, regulation 22 staffing and regulation 14 meeting nutritional needs.

Lofthouse Grange and Lodge is registered to provide accommodation and personal care for up to 88 persons. One part of the building accommodates older people with general care needs and the other provides care and support for people with a diagnosis of dementia or mental health illness. 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

Summary of findings

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 identified several areas of the home that were dirty and required more effective cleaning. Furniture was stained and dining chairs were damaged. Walls in the dining rooms had food stains on them and food debris was found down the side of kitchen cabinets.

People who lived at Lofthouse Grange and Lodge told us they felt safe living there. However, we found there were not always enough staff to keep people safe. We observed people waiting for assistance and in some cases becoming distressed when they had to wait for help.

During our last inspection we found people were being assisted out of bed very early. During this inspection we found this was still the case. We conducted our inspection at 6.30am and found several people were up and dressed. Some of those people required the assistance of two members of staff and as there were generally only two members of staff working on each unit we concluded people were still being got out of bed very early. We could not see from people's care plans that this was what they always wanted.

We looked at how the provider ensured the service was delivering safe and effective care and whilst audits had been carried out we found action plans had not been put in place to rectify any areas for improvement.

People told us there was not much opportunity to be involved in activities, although the activity coordinator told us about the programme of events for people.

We observed the lunch time meal and found the food looked appetising and appealing, however we did not feel in some cases the meal experience was a good one for everyone.

We saw some good interactions between people who used the service and the staff and management of the service. It was clear staff knew people well and understood how best to support them.

We looked at the administration of medication and found people were being given their medication as prescribed. We found the recording of the medication administered was good. Staff told us they had received the training required to administer medication safely.

Care plans we looked at contained good information and we found them easy to navigate around and they had been regularly reviewed.

We found people's concerns and complaints were not always resolved to their satisfaction.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Many areas of the home were dirty and unhygienic. We found faeces under a seat on a settee, and faeces were also found on the window ledge in a small lounge. Furniture was stained and damaged.

Staff, people who used the service and their relatives told us there was not always enough staff.

Staff had a good understanding of safeguarding and incidents were promptly reported to the local authority.

Appropriate checks were carried out to make sure staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective. We observed people who had been up early in the morning waited a long time before receiving their breakfast.

We found the breakfast experience for people was not always a pleasurable one. We saw a person being assisted with their breakfast in a way which compromised their dignity.

We saw good examples of capacity assessments which had been carried using guidance from the Mental Capacity Act 2005. There was no one subject to a Deprivation of Liberty Authorisation at the time of our inspection.

Staff received appropriate training to meet the needs of people who used the service.

Is the service caring?

Inadequate

The service was not always caring.

We found several people were out of bed very early in the morning, we had identified this at our previous inspection and found during this inspection the number of people up had increased.

Some people told us they were kept informed of changes in their relative's health whilst others thought the communication was not good.

During our inspection we observed some good interactions between staff and people who used the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Relatives of people who used the service told us their complaints and queries were not always actioned.

Summary of findings

We were told resident and relatives meetings were held. We were told concerns had been raised with regard to the standard of the homes environment but no improvement had been noted.

We observed people waiting for long periods before being assisted.

Visiting health professionals told us they were very happy with the service and the service responded appropriately to their advice.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found audits had been carried out of the service, however, where areas for improvement had been identified there were no action plans to ensure these areas were rectified.

We did not find evidence that concerns raised during our last inspection had been monitored to ensure people received a safe and caring service.

Some people told us the manager was approachable and was visible throughout the home, whilst others said they did not see the manager.

Lofthouse Grange and Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The unannounced inspection took place over two days, 26 November and 3 December 2014.

The inspection team consisted of two inspectors, a specialist advisor in nursing and two experts-by-experience with experience of services for those living with dementia. 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 we reviewed all the information we held about the service. We had not asked the provider to complete a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We contacted the local authority, and we took their views into consideration when conducting our inspection. We also reviewed notifications received from the provider.

We spoke with 23 people who used the service, the manager of the service and 16 members of staff, seven visitors and two visiting professionals. We spent time observing how people were cared for, we observed staff interactions with people in the lounges and also the lunch time meal experience in each unit. We looked at seven people's care plans and reviewed the provider's records about the service.

Is the service safe?

Our findings

We found there were several areas of the home that were dirty and unhygienic. We saw some toilets had not been cleaned to an acceptable standard or monitored for cleanliness throughout the day. In one bathroom we saw faeces on the wall behind the grab rail and the other walls in the toilet were generally marked and stained. There was a linen basket which had dirty legs. There was a crack on the wall which had the potential to harbour germs. In another bathroom we found bars of soap were in use and there was no access for people who used the service and staff to liquid soap. Most toilets did not have toilet roll holders; therefore toilet rolls were on shelves or on top of the toilet cisterns.

We looked in a small TV lounge and found one of the settees had faeces under the seat. There were several chairs throughout the home that had dirty arms. We pointed this out to a member of staff. We found one of the first floor dining rooms had very dirty cupboards, skirting boards, walls and cornicing. The sink was very badly stained and the sealant around the sink was cracked and dirty which again had the potential to harbour germs. We saw the floor around the cupboards was very dirty and did not appear to have been cleaned for some time. There were floor brushes stored at the end of the kitchen units which were very dirty. We found one of the microwaves we looked at was unclean.

In another lounge we found faeces on the window ledge, stains on the chairs and food debris under the chair cushions. We spoke with staff about the faeces on the window ledge and we were told there was someone who used the service who did this quite regularly. We could not see there was a plan in place of how to monitor this and therefore, protect people who used the service.

Most areas of the home were in need for re decoration. We found walls were very marked and it was difficult to ascertain what were scuff marks and what was food or bodily fluid stains. We were told by the registered manager of the service there was a paint budget for the home; however, the home did not appear to have been decorated for some time. We found several pieces of furniture which had rips on them; for example, in one dining room we saw the seats of the dining chairs had the foam showing which would be very difficult to keep clean.

These issues put people who used the service, staff and other people at significant risk of acquiring or transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people we spoke with told us they did not think there were enough staff. One visitor to the service said, “It is bad in the early mornings and weekends; breakfast is always late or missed altogether. I have seen residents waiting for breakfast at 9.30 a.m. some just get up from the table and walk away.” Another visitor told us, “I came on Wednesday and there was only one member of staff on this floor.” They also said, on occasions they could visit and it would take over 20 minutes to see a member of staff. Another person who used the service told us there was only one member of staff working at night and that was not enough. A visiting relative said, “I feel she is well looked after but there is no continuity of staff at times. If something happens in between visits, I don’t always get information passed onto me. I have raised this issue with the manager.” Another relative we spoke with said, “I have concerns over the level of staff changes and what effect this is having on my (relative).”

We observed staff undertaking their duties throughout the day and we found residents did not receive the care and attention required to fully meet their individual needs. People were left sitting at the dining tables on dining chairs for long periods of time, with no interaction between themselves or staff.

Staff were not always responsive to people’s needs. We observed one person asking to use the toilet, the member of staff told the person they would ‘need to wait until they had given another person their tablet’. The person continued to say they were ‘desperate’, we observed the member of staff then go to answer a call bell. Eventually the person said, “It’s too late I’ve gone.” We heard the member of staff say “No you haven’t.” After ten minutes the person was assisted to the toilet

We looked at staffing rotas and found the hours staff worked across the home was varied. From the information we saw we were unable to determine staffing levels for each day. For example we saw, on one day at Lofthouse Lodge we saw care staffing hours were 90 hours and on another day the same week the staffing hours were only 48 hours. The manager told us this was not correct and that the rotas had not been updated. A member of staff we

Is the service safe?

spoke with told us, “Sometimes I stay because there is not enough staff. We need a senior and two carers at medication time. Weekends can be a real problem; they don’t call in agency staff. I have worked straight through into a night shift that is 22 hours.”

We concluded there were not enough staff to keep people safe. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the administration of medication. Each unit had clinical rooms where the medication trolley was stored. The medication fridge and the room temperature on two of the units had not been recorded on a daily basis. On one of the units there had been gaps of up to five days when temperatures had not been recorded. Each room had a controlled drugs cabinet, where a smaller locked cabinet was stored for controlled drugs.

We checked the controlled drugs on two units and found the records were accurate and fully completed.

The ordering of drugs was carried out by the deputy manager for each of the units. The ordering procedure allowed time to sort out any discrepancies before the prescriptions went to the pharmacy.

We checked 20 medicines administration records (MAR) and found one discrepancy in the recordings. We found one person had not been given their early morning medication but we could not ascertain why that was.

We found the MARs sheet visual daily check had not been recorded on a daily basis. There was also inconsistent recording of daily cleaning being carried out in medication rooms.

We observed a medication round. People were given their medicines safely and were assisted where needed. Staff stayed with the person until they had taken their medication. Staff told us they did not take the medication trolley around with them, because even though they wore tabards, people and visitors had constantly disturbed them and asked them questions. We saw medication was taken from the trolley and the clinical room was locked before people were given their medication.

We found medicine stocks were checked and recorded appropriately and each person who was prescribed as required medication had an individual protocol in place. We also saw people who required medication to be given covertly had a signed letter from the GP agreeing for covert medication to be given.

We looked at three care plans and each had a medication assessment document in place. Information on medication and any allergies to medication was recorded in the assessment document. We saw that where people had allergies to medication a laminated red sheet was placed in the MARs file stating which medication it was. We spoke with three senior carers who told us they had up to date medication training. They said that the manager was very supportive of staff training.

We found safeguarding incidents were promptly reported to the local authority. Staff we spoke with could speak confidently about what they would do should they suspect abuse was occurring. We spoke with people who used the service and asked them if they felt safe living at Lofthouse Grange and Lodge. One person said, “Yes we are very safe we are looked after very well.” Another person said, “There is always someone around to help me.” We looked at the training matrix and found staff had attended safeguarding training in the last year.

Is the service effective?

Our findings

We saw people had access to food and drink throughout the day. However, we did have concerns that people who had been out of bed prior to our arrival at 6.30am had only been given a hot drink and did not have breakfast until after 9.00am.

We observed during the breakfast and lunchtime meals. We saw on one unit at breakfast time there was only one member of staff in the dining room with 10 people who used the service. The staff member was serving hot breakfast, making toast, making hot drinks, serving cereals, rinsing pots, filling the dishwasher and helping one person with their breakfast.

The staff member did not have time to sit and speak with the person who needed support and was just stood at the side of the person and helped the person as they were passing. The person's breakfast was scrambled eggs and bacon and it was in front of the person for 15 minutes going cold. On three occasions the staff member helped them with their food and during that time did not sit at the side of the person. We were told by a member of staff that it was a normal morning. They said, "One member of staff does the breakfasts while the other two members of staff help people to get up."

We observed the lunch time meal on one of the units and found at 12pm the majority of people who used the service were sat at the dining tables because they had been there all morning. We saw one person was asleep at the table. We observed people being offered 'wet wipes' for their hands. At 12.40pm the food trolley was brought in, we saw one member of staff serving the food whilst three members of staff took the food to people. The process was efficient and staff worked well as a team.

We saw one person would not sit at the table for long; they had a few mouthfuls of food and then got up. The person chose to sit in an armchair and staff brought a table to the person so they could eat in the chair. The person still did not want their main meal and staff took it away without offering the person an alternative. The person was then given a desert which they did eat.

We saw another person was not eating. Eventually, once everyone else had been served a member of care staff gave the person assistance whilst standing next to them. The person ate very little and was assisted in an undignified way. The food looked appetising and hot, portions were adequate. We did not observe anyone being asked if they would like more. We concluded this was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with people who used the service who told us they were well cared for. Some relatives told us they were kept informed of any concerns about their family member. One person said, "It's not unusual to get a phone call to say mum is not feeling well or that her medication needs changing even though we visit often." Another relative said, "They always tell me if mum has had a bad day." Someone else said, "They always get the doctor if my mum is unwell." However, we were told by one person who used the service they had fallen and banged their head but instead of calling an ambulance the GP had been called who checked them over and said they were alright. We saw significant facial injuries to the person.

We saw records which indicated people had regular access to health professionals, for example we saw a record of visits from the district nurse. This was monitored by the manager and deputy manager. The record we saw identified what treatment had been given to the person and any notes or observations made by the district nurse. We were told the local G.P. surgeries carried out surgeries within the home every week, however, if a person required more urgent attention the G.P. would attend outside of the routine visits.

We reviewed the training records of staff and found their training was relevant and up to date. We found in some cases staff filled in a 'training quiz' to check their competencies after the training was completed. Staff had attended courses for, mental capacity, food safety, infection control, dementia, safeguarding, moving and handling, health and safety and fire safety.

In the staff records we looked at we saw staff were given the opportunity to discuss any concerns they had during regular supervision sessions. Some of the supervision notes we saw included standard topics for each member of staff, for example, we saw during one session pressure area care had been discussed and during another session the results of the last CQC inspection was discussed. We found some supervision sessions were done with people

Is the service effective?

individually and others were group sessions. We saw some members of staff had received an appraisal and we were told appraisals were due to be completed during December.

We spoke with the manager about the Deprivation of Liberty Safeguards (DoLS). This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or their own safety. The manager told us she had been on recent training. Once the training was completed we were told they would be submitting DoLS applications to the local authority where it was deemed necessary. There was no one living at Lofthouse Grange and Lodge who was subject to a DoLS at the time of our inspection. Staff we spoke with had a basic understanding of DoLS and told us they had covered this legislation during their mental capacity act training.

We saw people had where appropriate been assessed using the Mental Capacity Act 2005. For example in one person's care plan we saw a mental capacity assessment had been carried out with regard to the person being given their medication covertly. In another person's care plan we saw the person had been assessed to see if they had capacity to make a decision about assistance with their personal care.

Is the service caring?

Our findings

During our last inspection we found there were several people who were out of bed very early in the morning. We conducted this inspection from 6.30 am and there were a greater number of people up than our previous inspection. On one unit we found there were six people up and dressed in the lounge, one of whom required the assistance of two members of staff to get out of bed and dress. On another unit we found there were seven people up and dressed in the lounge. A member of staff told us, there was also one person up and dressed in their room and another person was asleep in a chair in the quiet TV lounge. Four of the six people in the lounge needed staff to help get them up, washed and dressed. Of the four people, two people had also had a shower and another person a wash. On each of those units there were two members of staff who had worked the night shift which would mean people would have been assisted out of bed very early. On another of the units we found two people sat on chairs in the corridor one of whom was asleep, there were three people in the lounge, one person was laid on their bed dressed and another person was walking around the unit. Throughout the home we found there were 26 people up and dressed before 7.00 am.

As a result of our last inspection we asked the provider to tell us how they were going to ensure people were only getting up when they were ready to get up. The provider told us the night care manager was going to document the times people who used the service liked to get up on a morning in their individual care plans. We looked at the care plans of some of the people that were up and found little reference to what time people preferred to get up. In one person's care plan in said, the person 'likes to be up on a morning before the day staff'. In another person's care plan we saw entries in their 'daily communications' which related to the person not wanting to get up. For example it said, 'has refused to get up after a number of times of asking'. This was timed at 7.15 am. Another entry said, 'is still asleep, I have woken (person) twice but refusing to get up and goes to sleep again – will keep trying'. This was timed at 7.00 am. It was clear from the entries we saw in people's care plans and from our observations people were not given a choice of when they would like to get out of bed. We saw an instruction in staff supervision notes where the manager had advised staff they should not be getting people up too early and people should be able to get up when 'they are ready to get up'.

We saw one person making their way to the toilet independently which was located outside the lounge area; the person had wedged their walking frame in the door way while they were on the toilet. We spoke with a member of staff about this as we were concerned about the person's privacy and dignity. The member of staff said "The person needed prompting when they went to the toilet as they had some anxiety when closing the door when a member of staff was not with them." The inspector was asked to wait in the lounge area with six people whilst the member of staff went to assist the person in the toilet and also source a clean pad.

We concluded this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Friends and relatives of people who used the service told us they were always made very welcome and were offered refreshments and were told to help themselves to drinks. One relative told us they thought their relative always looked clean and 'well turned out'. However, we were told that clothes went missing on a regular basis. Another person said, "Clothes do go missing a lot; items do appear in mum's wardrobe that are not hers." Someone else said, "Underwear and clothing does go missing I have complained to the manager about this as I always have to buy replacement items even though I have spent hours clearly labelling all my (relative's) clothes." We were told by another person the home had offered to pay for missing items of clothing. Someone else's relative told us they always went to relatives meetings but was not sure how useful they were as they were not well structured or well led so nothing ever got done or changed. Another relative told us they did not know if their relative was supported in any hobbies or interests, no-one had discussed it with them.

Relatives and people who used the service told us they thought that on the whole staff were compassionate and caring. Residents thought that staff empathised with their needs but could be a little "short" at times because they were run off their feet.

Is the service caring?

Our observations throughout the day were that staff were kind to people and clearly knew people well. During the lunch time meal we observed a member of staff assist a person who was blind, the member of staff made sure the person knew what all the food was on the plate and said excuse me to the person when they reached over to get the salt for another person. A member of staff asked people if they had finished their meal and if they had had enough and had they enjoyed the food.

Is the service responsive?

Our findings

We saw minutes from the last residents and relatives meeting for both Lofthouse Grange and Lofthouse Lodge. Some comments from relatives were for example, 'there have been no activities since my relative moved into the home in January' and 'my relative is receiving other resident's clothing', and 'the dining room floor is shabby and worn, cupboards, sink and worktop is shabby and worn'. We saw the activities co-ordinator had been involved in the meeting and had given people information on 'what she was doing and had done', although the detail of this was not recorded. We could not see an action plan for these concerns and complaints.

We spoke with the activities co-ordinator who told us they arranged a different activity every day. On the day of our inspection it was hair and beauty. Most of the female residents had their hair done and nails painted. We were told activities on other days included arts and crafts, exercises, dominoes, reminiscences. Tuesday and Thursdays were taken over by a memory and fun quiz. We saw little evidence displayed of past events and celebrations except for a small pin board with some photographs pinned to it.

During our visit we did not see people taking part in any meaningful activity. Most people spent their day in the lounge/dining room area with very little stimulation other than at times music or the radio playing. There were no televisions in the main lounge area of the home, the televisions were situated in small T.V lounges, however, we only saw one person using a T.V lounge throughout the two days of our inspection. We found there were other small lounges designated for activities but again we did not see these areas in use. We concluded this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Another relative told us they had raised concerns at a residents meeting about staff shortages, the home running out of various products and water jugs and salt pots not being filled up. A person who used the service told us they told the manager about meals being late and no orange juice in the kitchen and not providing what they say is on the menu. People said these issues had not been resolved.

Two relatives we spoke with during our inspection told us they were unhappy with the lack of refurbishment of the home. They also said there were still issues with their family members not receiving their own clothing after it had been laundered. We were told these concerns had been raised with 'the management' but nothing had been resolved. A relative of a person who used the service told us they thought issues were not addressed by management or staff, it was always due to 'the people above' never the person they were speaking to.

There were some very positive comments in the residents and relatives meetings minutes. For example, one person had said, 'keep up the good work' and 'very grateful to care staff. The real strength of the home is the relationships between staff and residents'. Someone else said, 'I have been extremely impressed with the management and the care team'.

We were told by people who used the service that their pastoral needs were being met. One person said, they had Holy Communion every Sunday given by a local lay preacher. Another person told us they regularly had visits from the Salvation Army.

We found before people moved to Lofthouse Grange and Lodge their care needs were assessed and they had been given options of which room they would like. In the care plans we reviewed we saw a comprehensive pre-admission assessment. Care plans had been developed which included details of people's life history, a consent form for family involvement, for a photo to be taken and for the home to manage their finances. We saw G.P and hospital appointments were documented as was any involvement with other health professionals. We saw sections which included, personal care, physical well-being, nights care plan, pressure area risk assessment and nutrition and hydration. We found these had all been regularly reviewed and where necessary changes made to reflect people's current needs.

We spoke with a visiting health professional who told us, "I have no problems. They are pretty good." They said staff completed the cream and bowel charts satisfactorily. They also said "We can see the benefit of our instruction", "Palliative care is wonderful here" ,"They are passionate about the residents care and people look clean their nails are nice" and "There is no smell."

Is the service well-led?

Our findings

We looked at how the provider checked to see if people who lived at Lofthouse Grange and Lodge received care that was appropriate to their needs and was to a good standard. We found there was a deputy manager's daily floor check sheet, which was to be checked twice daily and included the cleanliness of the home, dining area ready to use, beds made, sluice and bathrooms, jugs in rooms and activities taking place. We looked at the check sheets from 10 November to 25 November 2014 and found there had been one daily check up to and including 13 November 2014 and then there was no record of the check being completed again until 25 November 2014 which was outside the home's policy.

We saw an infection control audit dated 4 September 2014 for Lofthouse Grange which had scored 75% (amber) but we did not see an action plan for how the areas identified were to be addressed. We saw a housekeeping audit also dated 4 September 2014 for Lofthouse Grange which had scored 52% (red) but again we did not see an action plan for how the areas identified were to be addressed. We saw an Infection control audit dated 27 August 2014 for Lofthouse Lodge which scored 83% (yellow) again we did not see an action plan for how the areas identified were to be addressed.

We looked at the Orchard Care Home compliance officer's report for September 2014 and we saw issues identified with medication management, missed signatures and missing as required medication guidelines, infection control concerns and environmental issues. However, we did not see an action plan for how these issues were to be resolved.

As a result of our last inspection the manager told us they were going to do spot checks of when people were being assisted out of bed on a morning. The manager told us she had done this, however, this had not been documented. We were told in the action plan submitted by the provider that group sessions would be held with staff, to ensure people were offered breakfast in the morning when they got up. We did not see there had been any checks by the management team to ensure this was happening.

We spoke with people who used the service and some of their visitors. Some told us they knew who the manager was and thought she had a very visible presence and felt confident and happy to approach her with any concerns they may have. We observed the manager interacting with people and their visitors in a friendly and personalised manner. The manager knew the names of people who used the service and was able to speak in some detail about them. However, some relatives we spoke with thought the manager could be more proactive in responding to concerns. One person felt that relatives should be informed about staff changes and they said, they had an ongoing issue with 'head office' with regards to them not responding to a letter they had sent. Another person said, "I know who the manager is but I don't speak to her, I usually speak with the deputy." One person who used the service told us, "I haven't seen the manager, they never speak to me." Another person said, "I don't have a clue who the manager is. They don't come and chat to me."

We concluded there was not an effective operation of systems to identify, assess and manage risk and to monitor the quality of service provision. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other relatives we spoke with told us the manager had dealt with very sensitive issues such as 'end of life' in a very caring manner that had given them much reassurance. They also said the manager had offered the lounge to them when it was their (relative's) birthday. They said, "We brought in all the food but the home decorated the room and provided all the cutlery." Staff we spoke with told us they mostly had involvement with the deputy manager, unit managers or the seniors on duty. One staff member told us they were happy working at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against risks associated with inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to check the quality of care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services and others were not protected against the risk of acquiring an infection because of the lack of appropriate standards of cleanliness and hygiene.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People who use services were not protected against the risks associated with not having adequate nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services and others were not protected against the risks associated with inadequate staffing levels to keep people safe.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that was inappropriate.

The enforcement action we took:
Warning Notice Issued