

Sanctuary Care Limited

Carlton Dene Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We inspected Carlton Dene Residential Care Home on 26 and 27 September 2016, the inspection was unannounced on the first day and we told the provider we were coming on the second day. This was the first inspection of the service since it had registered with a new provider Sanctuary Care Limited.

Carlton Dene Residential Care Home provides accommodation and respite care for up to 42 older people. The home is set out on two separate floors and divided into four units and provides an emergency bed that is commissioned by the local authority. At the time of our inspection there were 39 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.

People spoke positively about the food provided at the home. People's healthcare needs were assessed by the service and plans of care put in place. People were supported to maintain good health by a multi-disciplinary team.

Safeguarding procedures were in place, which were understood by staff. However, risks to people's health, safety and welfare were not continually assessed to ensure people received safe care.

There were sufficient numbers of staff deployed to help ensure safe care. Recruitment procedures were in place and these were followed by the provider.

Some staff did not receive regular supervision to ensure they received adequate support to carry out their roles. Staff had received training and were supported to develop their knowledge further.

'As required' medicines and stock checks were not safely managed and the storage of medicines was managed safely. Staff had received regular medicines training.

The cleanliness of the communal areas of the premises were not properly maintained. Checks were undertaken on the premises to ensure it was safe.

Staff cared for people in a caring and attentive way and ensured that their choices were respected. People and their relatives told us staff were kind and knew them well.

People had care plans to tell staff how they wished to be supported and involved in their lives in the home, however some of those plans were not fully completed and reviewed. People were supported with their care in a dignified manner.

People were supported to enjoy a range of activities and pursue their personal interests; however, some people wanted more support in the local community.

Appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made where necessary to the local authority. Staff understood the principles of the Mental Capacity Act 2005 (MCA).

Relatives told us they were not readily consulted about matters affecting the home. There were systems in place for handling and resolving complaints.

Quality assurance systems were in place to effectively improve the quality of care delivered; however, these were not always thorough in identifying and addressing shortfalls that we found. There were systems in place to seek and act on people's feedback. The management team were committed to making improvements to the home. Staff told us they felt supported by the management team.

We found three breaches of regulations relating to safe care and treatment, person centred care and good governance. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Medicines were not always managed safely.

The building was not well maintained to ensure people's safety. Checks were undertaken on equipment such as fire safety, gas and electrical systems.

Risks had not been appropriately assessed. Staff knew their responsibilities of how to keep people safe and report concerns.

Staffing levels were sufficient to meet the needs of the people using the service. The provider had good systems in place for the recruitment of new staff.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Not all staff received ongoing supervision to ensure they were adequately supported in their roles. Staff were offered and had completed training to carry out their roles and told us they were supported in their roles.

The legal requirements in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed by staff.

People were provided with good quality food and drink which met their nutritional needs.

Staff liaised with local healthcare services to ensure people had access to any specialist care or treatment required.

Is the service caring?

Good ●

The service was caring.

People and their relatives told us they were cared for by kind and considerate staff. People's privacy and dignity was respected and their views were listened to.

Advocacy support was available to people who lived in the home.

Is the service responsive?

The service was not consistently responsive.

Care plans had not been reviewed to ensure people received appropriate care to meet their individual needs.

A range of activities were provided and people were supported to pursue their personal interests, however people required support to remain active in the local community. Staff were responsive to people's needs.

People knew how to raise complaints and these were acted on.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Systems to assess, monitor and improve the service were in place. However, these were not always thorough in identifying and addressing shortfalls.

Relatives told us they had not been readily consulted about matters affecting the home. There were systems in place to seek and act on people's feedback.

The management team were committed to making improvements to the home. Staff told us they were supported and the management team were available to assist them.

Requires Improvement ●

Carlton Dene Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 27 September 2016. The first day was unannounced and the second day was announced. The inspection team consisted of one inspector and an expert by experience on the first day and one inspector on the second day. 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, previous inspection reports and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider.

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

We spoke with four people who lived in the home, three relatives and one visitor. We spent time observing the care people received including the activities they attended. We also listened to the staff handover and viewed the building.

Additionally we spoke with four care workers, two residential managers, the training and development officer, the activity coordinator, the chef, the night manager, the regional manager and the registered

manager. We looked at the records in relation to six people's care including their medicines records. We also viewed six staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the records relating to the management of the home.

Is the service safe?

Our findings

People were not always protected from avoidable harm as risks were not always appropriately managed to ensure people's safety. Medicines, including controlled drugs were stored and disposed of safely and staff received training and their competency was checked. Medicines were handled separately on each floor and stored in separate medicines trollies. We observed the administration process in the morning and saw this was completed safely. We observed a member of staff administering medicines and saw that they offered each person their medicines in a discreet and unhurried way. Medicines administration charts (MARs) were signed by a staff member the majority of the time. However, 'as required' medicines had not been signed for by two people when administered. We checked the stock count for medicines on the ground floor and found that for one person there was an error between the number of tablets recorded following a stock count and the actual number in the medicines box. Therefore, we could not be assured that medicines were managed safely.

We saw that individual risk assessments had been carried out in some areas and management plans had been put in place to reduce the risk of harm occurring. For example, a falls risk assessment had been carried out for one person and 24-hour one to one care had been put in place to help keep them safe. A falls checklist was completed in people's files and there were sensory aids and equipment in place to make sure people were safely supported. However, we found that risk assessments were not always reviewed to ensure that these still accurately reflected people's needs. For example, we saw that risk assessments had not been reviewed for staff assistance with moving and positioning people; a person who had experienced falls and a risk assessment for a person's medicines. In addition, there were risk assessments that had not been reviewed regarding people's skin care and nutritional needs. The residential manager who supervised the floor acknowledged that the risk assessments had not been reviewed. This meant that the provider had not done all that was possible to mitigate risks to people's safety.

During our visit we found some areas of the home had not been thoroughly cleaned. For example, the hand wash basin in the communal bathroom, the activity room and adjoining kitchen. The inside of the kitchen cabinets were stained and marked with lime scale and unwashed crockery and cutlery was stored in cupboards. Kitchen surfaces were sticky from food debris. One relative told us, "[My family member's] room is kept very clean but the building is very shabby looking and it could definitely do with improvement on the cleaning. But on the other hand I'd rather have that and good care for [my family member]." In one of the communal bathrooms, we saw the sink was not clean and under the sink cabinet, there were unused stained items and this area was generally unsanitary. The windowsills and ledges were dusty in the activities room and bathroom. Therefore, people who lived in the home were at the risk of infection because they were using facilities that were not clean. Other areas of the home had been more thoroughly cleaned including the bathrooms and the toilets and communal areas. We discussed this with the regional manager who told us some of the areas of the home were not used, however agreed to act on this.

We looked at the documentation the home held in respect of the checks undertaken in relation to the hot and cold water temperatures. These must be carried out to ensure people are not at risk of scalding themselves and to make sure their safety is not compromised. These were carried out by maintenance

workers however, we found only three out of the four units had been checked. The registered manager agreed to address these issues with immediate effect.

The issues in the four paragraphs above were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the home were in a poor condition, with damaged kitchen cupboards and chipped woodwork. Some empty communal rooms in the building were being used for storage including furniture not in use. The registered manager told us these areas were not used and accessible to staff only using protected door codes. There was a cracked window and we saw that the maintenance worker had been contacted to repair this. A health and safety report highlighted areas in and outside the home that required improvement and identified environmental hazards. To ensure the home was kept safe for people, professional maintenance and servicing of equipment was routinely carried out, such as window restrictors, security door systems and lifts. Legionella checks were also conducted to ensure the safety of people's health and well-being. Regular fire tests and drills were carried out and individual personal emergency evacuation plans (PEEPS) were completed and kept in people's care records. The regional manager told us of the landlords plans and intended changes to the building.

People told us they felt safe and received good care from the staff who worked in the home. They told us, "I'm gradually getting used to some of the girls the staff are pretty good" and "I do feel safe I can lock my own door here at night." Staff were clear as to whom they would report any concerns relating to people's welfare and were confident that any allegations would be investigated by the provider. Staff said that, where required, they would report concerns to the local authority safeguarding team and the Care Quality Commission (CQC). Staff had received training in this area and policies and procedures were in place to provide them with additional guidance if necessary. The registered manager recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Appropriate referrals and discussions had taken place with the local authority over safeguarding alerts and concerns. We found the correct processes were being followed and measures had been put in place to keep people safe.

Recruitment records showed that the registered manager carried out appropriate checks about employees suitability before they started work. The checks included evidence of the candidates experience, good character and criminal record checks. This showed that there was a system in place to make sure that staff were only employed once the provider was satisfied they were suitable to work with people who lived in the home.

People told us there was enough staff on duty to meet their needs. One person said, "There are enough staff. I need help with a bath and every day I can wash myself," and "There are enough. They help me with a bath 3 times a week or more if I wanted to." The provider determined staffing levels based on people's assessed needs. We saw evidence from staff training records and staff rotas that there were enough staff on duty staff to meet people's needs. We observed that the staffing levels were sufficient on the days of our inspection to assist people promptly when they needed support.

Is the service effective?

Our findings

People were not always cared for by staff who were adequately supported in their roles. Not all staff received regular supervisions. We asked the registered manager how often staff had supervision meetings and she told us this was five times a year. We looked at the supervision matrix and found for two staff members that consistent regular supervisions were not undertaken. For one staff member supervision was carried twice in March 2016 and October 2016 and for another we found one supervision was completed in May 2016. We asked for records of these meetings from the residential managers, who told us they had been done but they could not locate the records. This was not in line with the providers policy which states 'A written record must be kept of the content and outcome of each meeting.' Staff should receive appropriate ongoing supervision to ensure their competence to undertake their role. The registered manager acknowledged this and agreed to make this a priority.

Relative told us, "There are enough staff but they need proper dementia care training. I've raised this more than once but I have my doubts about them being trained properly," and "Some of them can be a bit brusque because they don't know what to do. They need more training and more insight into what people's needs are." The registered manager told us they were a dementia champion and some staff were developing further skills to support people living with dementia. The training and development officer told us about the face-to-face learning on dementia care and other areas of learning that were included in their training plan. They talked about the content of the course and the workbooks to be completed in the coming weeks. We spoke with staff about the training they had done and how further learning would help them with their role in supporting people living with dementia. Staff records showed they had completed training that included a comprehensive induction, first aid, nutrition, infection control, fire safety and pressure area care awareness. The care staff we spoke with had a recognised qualification in health and social care and had attended yearly appraisals.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The provider had made applications to the local authority for DoLS authorisations for people who lacked capacity to make specific decisions and required restrictions to ensure their safety. For example, when accessing the community staff accompanied a person due to their lack of road safety awareness. The registered manager told us they were waiting to hear the outcome of these from the local authority. We saw records in people's files to show that they had given their consent to care and treatment where they had the capacity to do so. One person had signed an agreement to administer their own medicines and other care plans showed the reasons why people could not sign the care plan and where they had refused.

People told us they were supported to eat a well-balanced diet. They said, "They do the food well", "You do get choices of food I have to have mine pureed," and "The food needs to improve I only have my pension and I spend it on my fresh food." We looked at the kitchen and found that staff followed safe food hygiene practices, for example, probes were used to check that food was served at a safe temperature. We found the cupboards were stocked with fresh, tinned and baked goods. The chef told us they cooked the foods from scratch and we saw examples of this. There was a list of people's dietary requirements in the kitchen so that appropriate foods were prepared for individuals. The chef told us that people's requests for specific food were accommodated, however we saw that one person was not happy with the choice of food provided and went out to purchase their own food. One member of staff spoke to this person and explained that the chef would cook this for them in the evening.

We observed lunch being served and found that people received well-balanced meals. On one floor, music was playing in the background and everyone was offered a choice of drinks. One person refused the plate of food and was given an alternative option that they enjoyed. A relative said, "The food's absolutely fine. They get two choices and support with eating and drinking." Staff asked people if they were enjoying their meals and offered them second helpings. Assistance with drinking was given by staff where and when this was needed. For example, people unable to hold their own cups were supported to drink ensuring they received enough fluid to keep them hydrated. Throughout our visit, we noted that people were regularly offered drinks. The provider liaised promptly with other professionals such as dietitians and speech and language therapists to meet people's nutritional needs where required.

People were supported to maintain their health needs because they had prompt access to health care professionals. They said, "I see the GP who always visits on a Wednesday" and "The optician comes and I do need to go to the dentist." A relative commented, "They got a dentist to check on their teeth and they had a blood test so that's OK." Care records we viewed showed people had access to a range of healthcare professionals such as the involvement of GPs, district nurses and the falls prevention officer. Health related care plans for example oral hygiene and personal care had been developed by the services. This was to ensure people's needs were met by the home and action was taken if people's healthcare needs deteriorated.

Is the service caring?

Our findings

People and their relatives told us that they were supported by kind and caring staff who knew them well. People commented, "They do know me well", "Everyone is very nice and they're OK", "There are two who know me and are very good," and "They treat me as I would treat them." Their relatives echoed this and reported, "The staff and carers are conscientious and caring," and "I think they are very kind here. They give extra attention and always look to one another, checking if people are Ok."

We observed that staff interacted and supported people in a caring and attentive way and that their choices were respected. For example, during the mealtime we saw that a person was asked to sit at the dining table but refused and wanted to sit on their own and this was respected. People's views and comments were listened to and acted on through residents meetings and where people were chosen to be 'resident of the day'. Being 'resident of the day' involved members of staff having discussions about people's individual needs and preferences and acting on this which helped staff to understand the experiences and wishes of people who lived in the home. Advocacy support was available to people if this was requested.

We noted throughout the visit that staff supported people in a courteous and dignified manner and responded to people's requests. One visitor said, "The staff are very kind and sweet. I came to a barbeque party here once and it was fantastic. They do a great job. Staff here really do care for people." During an activity, one person said they were cold and asked a member of staff to bring them a cardigan to keep them warm, and the care worker readily assisted and helped them to put this on. Staff had conversations with us about people's backgrounds, interests and specific healthcare needs. A care worker told us, "Some residents here suffer from dementia but we look beyond the illness they have."

People told us staff respected their privacy and said there were no restrictions on relatives or friends visiting them at the home. We saw that bedroom doors were knocked on prior to the staff member entering and that conversations with people were appropriate. The open courtyard had tables and chairs outside, and was a pleasant space for people to sit and we saw a person sitting outside reading a paper during the afternoon. Care plans included people's views and their decisions about how they wished to be cared for as well as their likes and dislikes. These included 'I love to get up early in the morning and for someone to give me a cup of tea', 'I like listening to Arabic music' and 'I like my privacy'. There were photographs of staff located in the home so people could identify which members of the team were on duty.

Is the service responsive?

Our findings

People's care plans had not always been reviewed and updated to ensure the service was responsive to their needs. People's care needs were assessed prior to them moving into the home and staff told us this was then used to draw up the person's care plan, which provided guidance to staff on how to support people. Although staff were aware of people's care needs, we found that three care plans had not always been updated to reflect their current needs. For example, one person's care plan stated that they were unable to sign it due to poor eyesight and this was due to be reviewed in July 2016, however, this had not been done. Another person's residential information sheet asked if their relative would like to be notified of any changes to their condition during the night and this was not completed. One relative told us, "We weren't involved in [in our family member's] care plan or anything." A third person's care file had not been reviewed in relation to their nutritional requirements. This meant that people were at risk of their needs not being met appropriately.

Care records did not always provide sufficient detail to staff to ensure that people received personalised care. For example, we looked at the care records of some people who were living with dementia and some people who required less support. We found some people's personal histories were well written, but some provided a very brief description that did not include person centred information about people's background and histories such as their previous employment and interests. The regional manager explained they would soon be implementing new care plans where the information would be reflective of person centred care.

There were regular church services for those who could not easily be taken to their chosen place of worship. In addition, staff were able to show us how they met the diverse needs of people with a range of religious beliefs, for example relating to their dietary requirements and personal care. However, although some people were assisted in the community to meet their spiritual needs we could not be assured that people were receiving adequate support as the engagement logs we saw were incomplete and therefore did not show the activities people had participated in. For one person we found that the engagement log was not completed and for another person the engagement log was completed up until May 2016. One person said, "I'd like to go to mass but there's no one to take me, they say my family could take me. They take people to the protestant one sometimes." A relative told us, "I'd like them to take her outside so she can get used to walking on uneven surfaces it's all flat and smooth in here," and "Everything I have seen is satisfactory but also once in a while it would be good to have someone speaking in his/her language." Therefore we could not be assured that people's individual social, cultural and spiritual needs were met.

The above issues were a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke to some people, they told us they were independent and did not require support with some of their daily routines. Their comments included, "I don't like doing the activities I do my own exercises", "I like knitting and I can go out with my friends to buy wool", "I like to do my own cleaning and save my energy to do that in my room also preparing my own lunch," and "I'm independent and able to go out in my

wheelchair." A relative said, "My [family member] is not allowed out by themselves and they are very careful to check who is OK to take [family member] out."

People told us there were activities taking place in the home, which they could participate in if they wanted. People commented, "I like reading and watching TV", "You can get books here," and "We got asked in the dining room once about what TV programmes we like to watch." Relatives explained, "I see they have papers, activities and a lot is going on," and "[My relative] does the exercise classes on Mondays." The activity co-ordinator spoke enthusiastically and positively about their role and told us of the activities they had organised. We saw there was a planned programme of activities that included art, bingo and exercises. During the visit, we observed a good number of people participated in singing sessions, puzzles and balloon games. We noted that people with sensory impairments and mobility needs were alert and responsive and we saw they particularly enjoyed the interaction with the balloon games and songs. One person with sensory needs stood up enthusiastically to continually reach for the balloons and another sang joyfully during the singing session. On the second day of our visit, one person was celebrating their birthday and staff had provided a large cream fruit cake, the care worker told us how much the person enjoyed fruit. A silver Sunday tea dance had been organised for people to celebrate and listen to live music from their era and enjoy homemade afternoon tea.

Relatives told us that staff listened to them and addressed concerns about their family members and one relative said, "My [Family members] hand used to get stuck down the side of the bed. I spoke to the staff about it and they followed it up. Every time anything is wrong, they do respond especially the previous manager who was very good." Advice to people and their relatives about how to raise complaints was provided in an information leaflet and was given to people when they first started using the service, however, one relative was not confident their concerns would be listened to and acted on. The complaints file showed that there had been one complaint and this had been acted on and resolved. The registered manager demonstrated their awareness of how to work with other agencies should any concerns be raised.

Is the service well-led?

Our findings

Regular audits of people's medicines, the environment, care records were not carried out thoroughly by the provider to identify and address shortfalls including risks associated with people's wellbeing. Records in relation to staff supervision were not accurately maintained and carried out consistently for all staff. This meant that systems were not effectively monitored to improve the quality and safety of the services provided to people.

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

The registered manager had worked for the provider in other homes and had recently been recruited as the new manager in the home. Three residential managers supported the registered manager in their role and had worked in the home for numerous years. During the visit, we were informed that there had been a staff restructure which meant that the posts for the residential managers were being replaced with a new role. The residential managers told us they had enjoyed their time but had made the decision to move on. One residential manager said, "The new manager has been helpful and supportive, it makes me feel better, even though we are currently winding down we still want her to succeed."

These changes had caused uncertainty and relatives told us they had only been consulted a week prior to the inspection about the proposed changes relating to the staffing restructure. Relatives commented, "We're very worried about all the changes here and disappointed in Sanctuary Care. They haven't contacted us about the changes here. We got a letter a year ago, but they never told us about the changes with the senior staff. We couldn't make the meeting they had here on Saturday. All those managers were very good and now they've gone" and "The previous managers used to put people first. Having a meeting last Saturday was way too late to tell us about the senior managers leaving." This meant that relatives were not consulted in a timely way about the changes to how the service would be delivered.

The registered manager and regional manager acknowledged this and empathised with people's concerns. They told us there was a commitment to further improve the service and manage change. This included senior staff having a more "hands on" role to support people with their care needs and they would be based on all the floors of the individual units. This was also to make sure that staff who worked on the floors were more closely supported with their daily duties.

The registered manager told us they felt well supported by the provider and a regional manager. All the staff we spoke with explained there were regular visits by the regional manager to support them in their roles. The regional manager was available during the two days we inspected the service. Staff we spoke with said they felt well supported by the registered manager and they were able to contact them at any time. One person said, "I can ask them anything they are very good to people here." We saw the registered manager respond to people's requests and address staff conduct in the home. One visitor said, "I think here, they put the person first." We had a discussion with a healthcare professional who told us people were well supported and there was good communication from the staff team.

We listened to the staff meetings held in the morning on both days of our inspection where all members of the team discussed the division of staff responsibilities during the day. This included any updates on the home, such as people's catering requests, maintenance, activities, people's health, DoLS applications and cleaning duties.

Staff understood their responsibilities for reporting accidents and incidents. Accident and incident forms contained a good level of detail including the lead up to events, what had happened and what action had been taken. However, in one case, there was an incident where a person had fallen during the night, but there was no information on the incident form following the concern about what actions were taken. The residential manager checked this and found the actions taken were logged in a different file. We asked the registered manager to ensure all of these forms were thoroughly completed. Any injuries sustained were recorded on body maps and monitored by the staff on duty. Monthly audits helped to identify any trends to help ensure the prevention of reoccurrences. The residential manager told us how they monitored for signs of infection as a possible cause if people's healthcare needs had deteriorated and reviewed medicines with the GP. If a person had fallen, they reviewed the environment to see if risks could be eliminated for example moving furniture and referring people to a physiotherapist.

Periodic residents meetings were held where topics such as food and activities were discussed. People and their relatives told us their overall view of the home and how this could be improved. Their comments included, "I wish they would tune the pianos, we've asked a few times", "I don't use the hair salon it costs too much. I go to the barber shop for a cheaper hair cut", "There's no private room except my room and it gets a bit crowded with the family visiting," and "There used to be someone who could speak [my language] but not now." In addition, a relative said, "What's good is the TV, radio and food. They could improve, there's a staff that goes around slamming doors. Also taking [my family member] for a walk outside and to mass occasionally and also a better care plan."

The provider had signed up to the Social Care Commitment. This is the adult social care sector's promise to provide people who need care and support with high quality services. The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>How the regulation was not being met:</p> <p>Care and treatment of services users was not carried out collaboratively with the relevant person, and assessment of their needs and preferences.</p> <p>Regulation 9(3)(a)(b)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks to ensure the proper and safe management of medicines, maintaining the suitability of premises and detecting and preventing the spread of infections.</p> <p>Regulation 12(1)(2)(a)(b)(d)(g)(h)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p>

Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17(1)(2) (a)(b)(c)