Oakhurst Court Limited

Oakhurst Court Nursing Home

Inspection report

Oakhurst court
Tilburstow hill road
South Godstone
RH9 8JY
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Website: www.oakhurstcourt.co.uk

Date of inspection visit: 11 June 2015
Date of publication: 15/09/2015

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?	Good

Overall summary

Oakhurst Court is a care home that provides nursing and personal care for up to 57 people. Many of the people living at Oakhurst Court are living with dementia. The home also provides respite care and palliative care. At the time of our inspection 49 people were living at the home.

This inspection took place on 11 June 2015 and was unannounced.

The home is run by a registered manager, who was present on the day of the inspection. 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 and associated Regulations about how the service is run.

Summary of findings

We found the home did not have a sufficient enough number of trained staff deployed to meet the needs of the people who lived there.

Where restrictions on people were in place to deprive them of their liberty, staff had followed legal requirements to make sure this was done in the person's best interest. The registered manager had submitted Deprivation of Liberty Safeguards (DoLS) applications to comply with their responsibilities.

Complaint procedures were available for people. The registered manager had received complaints and was responding to them.

People were involved in their care and support however we did not see staff encourage people to do things for themselves. We found staff did not always make people feel as though they mattered or treat them with consideration.

Staff told us and we saw ways in which staff supported and enabled people to maintain their independence and take part in various activities. However we saw people sitting for long periods of time without social interaction from staff. Appropriate activities for people living with dementia were not always provided.

Care was provided to people by staff who were not always competent to carry out their role effectively. However staff did not always show they had an understanding of the needs people living with dementia have.

Staff told us they received supervision, and appraisals.

Checks had been carried out to make sure people were safe living in the home and any risks they may take were minimised. Incidents and accidents were recorded and investigated in a timely manner by the registered manager.

Medicines were managed appropriately and people received their medicines in a safe way.

The provider had ensured they followed good recruitment processes to help them employ suitable staff to work in the home.

Staff understood their responsibilities in relation to safeguarding. We were assured they knew how to report any concerns they may have.

A choice of meals was provided to people and people were involved in making decisions about what they ate. However staff did not always support people to eat and drink to support their wellbeing.

Staff referred people to external healthcare professionals when appropriate and the local GP was actively involved in the home.

Care plans contained information to guide staff on how someone wished to be cared for. When people's needs changed, staff did not responded to these appropriately and provided effective, responsive care.

People's views were obtained by holding residents' meetings and sending out an annual satisfaction survey. Complaint procedures were up to date and people and relatives told us they would know how to make a complaint if they needed to.

The provider had effective quality assurance systems in place, including regular audits on health and safety, infection control, dignity, care plans and medicines. The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

Staff followed good medicines management procedures.

There were not enough staff on duty to meet the needs of the people and appropriate checks were undertaken to help ensure suitable staff worked at the service.

Staff were aware of their responsibilities in relation to safeguarding and people's risks had been assessed and were managed effectively.

The service was not always clean in all areas.

Is the service effective?

Requires improvement

The service was not always effective.

The registered manager had a good understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act.

Staff were not trained and supported to deliver care effectively in relation to people living with dementia.

People were not supported with enough food and drink throughout the day.

Staff ensured people had access to external healthcare professionals when they needed it. People's changing health needs were monitored by staff.

Is the service caring?

Requires improvement

The service was not always caring.

We observed occasions when people were not treated with the attention they should expect from staff. We saw people sitting for long periods of time with little social interaction from staff.

Staff supported people make their own decisions about their care.

Regular staff knew people well and welcomed visits from friends and family.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were supported to participate in a range of activities; however there was a lack of individualised stimulation for people living with dementia.

People were able to express their views and were given information how to raise their concerns or make a complaint.

People and their relatives were involved in developing care plans and changes to people's needs were reflected and acted on by staff.

Summary of findings

Is the service well-led?

Good

The service was well-led.

The staff were well supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns.

The registered manager regularly checked the quality of the service provided and made sure people were happy with the service they received.

Notifications of incidents were submitted to the CQC as required by law.

People who lived in the home and their relatives were asked for their opinions of the service and their comments were acted on.

Oakhurst Court Nursing 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 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 11 June 2015 and was unannounced. The inspection team consisted of three inspectors.

On this occasion we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding to some concerns we had received.

As part of our inspection we spoke with seven people, seven staff, three relatives, the registered manager, nominated individual and two healthcare professionals. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff.

We reviewed a variety of documents which included six people's care plans, five staff files, and policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We last carried out an inspection on 22 November 2013 when we had no concerns.

Requires improvement

Is the service safe?

Our findings

People felt there were not enough staff on duty. One person said "I feel there aren't enough staff, I have to wait for staff to come when I ring the bell." Another person said when they requested help; staff could take some time to come to their assistance. People told us the delays would "depend on what was going on." Another person said; "Staff had time to talk to people more in the afternoon when things were calmer." Staff told us there were not enough of them to meet people's needs. One told us they were rushed "All the time."

We found that there were times that there were not enough staff to support people particularly in the morning. One person was not supported to get out of bed until noon although they had requested several times throughout the morning to get up. Staff were not able to give people time and as a result people were walking in and out of each other's rooms unsupervised. Staff did not always respond to people quickly and there were times when there were no staff available to see to the needs of people. We saw one person waiting to be assisted for over 30 minutes, whilst another person called out on and off for a period of 20 minutes when no staff were in the room. A relative told us that they had visited and their family member could not be found for a considerable period of time. They were eventually found in someone else's room but staff were unaware of this. Although staff were aware of the risks for people they did not always know where people were due to the lack of staff being available.

The registered manager told us that there should have been two nurses and nine or 10 care staff on duty in the morning and seven care staff in the afternoon but they were unable to demonstrate how the staffing levels were determined. We looked at the staffing rotas and found that there were less than the required numbers of staff on at least 16 occasions over a four week period. There were also occasions at night when staffing levels were less that the required amount.

There was regular use of agency staff and the registered manager told us they tried to use the same staff to ensure continuity however they recognised that it was proving difficult to recruit staff despite them trying different ways of attracting them by offering increased pay for example.

There were not enough staff deployed to meet people's needs. This a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were in place. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. We saw staff had Disclosure and Barring System checks to identify if they had a criminal record. Application forms had been fully completed; with any gaps in employment explained. Notes from interviews with applicants were retained on file and showed that the service had set out to employ the most suitable staff for the roles. Nursing staff had their registration checked to make sure it was up to date

The premises was not always kept clean or properly maintained in line with current legislation and guidance. Items used for cleaning the service were stored in a room which also houses two boilers. The room is very warm. Fumes from the containers were strong. We viewed the safety data sheets in the COSHH file, which is located in the laundry. Directions for storage were to be in a cool, well-ventilated area away from sources of ignition. The location of the COSHH does not meet these requirements.

We spoke with domestic staff regarding systems in place to maintain a clean environment. We were shown documentation from 2014 regarding quarterly spring cleaning. The staff member was unable to show us evidence for any spring cleaning undertaken thus far in 2015.

We saw a room check list, the list did not clarify which areas required cleaning and how frequently. The document had a room number or area which requires a tick to state the area has been cleaned. We did not see evidence regarding audits of work carried out to establish acceptable standards were being maintained.

In one person's room the mattress was to long for the bed, it was un-personalised and some furniture broken. Another person room sheets stained, no door for toilet, carpet had a hole in it, curtain rail falling down at one end and in another person's room the mattress didn't fit, pillow down in gap near headboard, sheet stained, bed rail bumpers were stained, carpet torn and there were stains on the wall.

Requires improvement

Is the service safe?

We spoke to the registered manager about these issues and were told that the home is going through changes and areas of improvement. These issues had been identified and action plans were in place to rectify them.

The premises was not always kept clean or properly maintained. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The director explained to us that refurbishment of the home was on going, and they were aware of issues with odour in the home. The directors said "We are working hard to eradicate the problem by replacing furniture and carpets as necessary" and "We have a company to clean the carpets once a month and the cleaners were working some evenings to try to combat the problem."

Staff were aware of their responsibilities in relation to safeguarding and could recognised signs of potential abuse. Staff gave us examples of the types of abuse and how they would act if they had any concerns. One member of staff knew about safeguarding and told me how they would report it. Although not all staff were aware of the role of the local authority there were policies available for staff in the office which they knew how to access. Guidance was available for staff to follow if they wished to report anything which staff knew about. We looked at records of safeguarding incidents in the home and found the registered manager had responded appropriately to them.

People were enabled to take risks in a protective environment. We saw people walking around independently throughout the day and staff allowed their freedom. People's care plans included information around risks for individuals, such as their mobility, skin integrity, and risk of malnutrition or dehydration. For example, we read one person who was at risk of falls had a bed rail fitted. Another person who was unable to use the call bell was encouraged by staff to sit in communal areas throughout the day. We saw this happening during the inspection. People living with dementia were able to access communal areas unaided.

People received their medicines as prescribed and staff followed current guidance in relation to the management of medicines. We saw staff give people their medicines after checking the information contained in their medicines administration record (MAR). MAR records included a photograph of the person, any allergies they may have and information related to what medicines they were on and when they should be taken. Individualised medication care plans were in place for people. We read people who required PRN (as required) medicines had protocols which described to staff how, why and when a PRN medicine should be given. Some people required PRN medicines on a daily basis which meant they had become a regular prescription. We read staff had requested the status of the medicine to be changed.

People received their medicines when they required it. We watched staff give those people who required medicines at the appropriate time. People were given time to finish their supper before staff administered the medicines and they watched to ensure people swallowed their medicines before updating the MAR record. Medicines were stored securely and reviewed when appropriate. We saw staff recorded fridge temperatures on a daily basis and all boxed medicines had an audit chart for staff to count stock levels following the dispensing of tablets.

Requires improvement

Is the service effective?

Our findings

People said "The food was sometimes good and sometimes not." People told us that they did not always get the food choices they requested and did not feel that staff listened when they wanted something else to eat. Other people told us they did not enjoy the meals prepared; they always chose to have a sandwich instead.

People were not always supported to have enough to eat and drink and the dining experience for people was variable depending on where they ate and who supported them. During the inspection we were advised that building work was on going in the dining area. As a result of this work people were having their meals in the main lounges, their bedrooms or the activity room. We observed lunches in three different areas of the home. We saw ten people in the main lounge during lunch. All, bar two, were eating independently. People appeared to enjoy the food and cleared their plates. One person was being supported to eat by a staff member who was just standing beside them; there was no social interaction or explanation from the staff member about what they were doing. Another person was very restless during lunch, they were bought a sandwich by staff which was left on the side and the person did not eat it. Staff did not encourage the person to have any further food or drink which was not in line with their care plan.

Not all people were provided with drinks in their rooms and some of those that had were not placed close enough to them to. One person had not been given a drink or had a drink available in their room for over 90 minutes. We saw that people in their rooms did not have easy access to drinks. Some jugs of water were out of reach of the person and other people did not have drinks available. During lunchtime observations we saw staff providing squash to the people, we did not see staff giving the people a choice of drink. We saw staff place the drink in front of the person and then explained that this was their drink. We saw one person struggle to reach their drink as it had been placed too far from their reach.

Staff we spoke with told us a menu was prepared by the chef and manager. We saw photographs of the day's meal on display in the hallway. Staff told us the people were advised of the day's meal. If they did not want this meal then an option of omelette or sandwich was provided instead. Staff told us the people in the service were not involved in creating the menu for the service.

The lack of support in relation to people's nutrition is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people with complex needs were identified. Staff ensured they told the chef of people who required a soft diet, for example, or those who could not eat certain foods. The information was contained on a board in the kitchen and updated regularly by staff. People who required it had access to dietary and nutritional specialists who provided guidance for staff to follow. For example, we saw one person had been referred to the dietician. Staff told us of the importance of recording what people ate and drank and why it was necessary to weigh people regularly. Where people were at risk of malnutrition they were weighed regularly and actions taken to address this.

Where people may not be able to make or understand certain decisions for themselves, the registered manager and staff had followed the requirements of the Mental Capacity Act (MCA) 2005. We found mental capacity assessments had been carried out for people in relation to individual decisions and there was evidence that best interest meetings were held to discuss a decision and how it could be made with the least restriction for the person.

The registered manager had submitted Deprivation of Liberty Safeguard (DoLS) applications for most of the people living in the home. We found people were restricted to areas of the home. For example, all major external doors and most internal doors were locked and had key coded access.

These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Staff we spoke to had a good understanding of MCA and DoLS. They were able to describe when you there would be a best interest meeting and the sort of thing a DoLS application would be made for. The registered manager sent us the staff training plans that staff had received training in MCA and DoLS.

People were cared for by staff who were trained in their role. Staff told us the training they received was good and it was sufficient and appropriate to enable them to carry out

Requires improvement

Is the service effective?

their duties. One staff member said they started as a carer first (for a year) before they got there nursing PIN number. "I had a good induction and shadowed more experienced staff for one month before working independently."

They said they had constant supervision during that time. "Since becoming one of the nurses in the home I have continued to receive supervision and am on slightly restricted duties until I complete all the necessary training and competencies required to nurse in the UK." Another staff member told us they had recently had medicines training and dementia awareness, but had not had any other specific training related to the types of conditions people may be suffering with in the home. The registered manager was responsible for providing clinical supervision for the nursing staff which they told us they received and was up to date.

Staff received basic training specific to their role for supporting people who live with dementia. The training included sessions on dementia awareness and working with people whose behaviour challenges others. However, we did not find staff always put their training to use effectively. For example, staff did not have an understanding of how the person's dementia individually affected them and how they could use this information to provide personalised support. .

Staff ensured people's daily health needs were met. The GP came to the home once a week to review people who were not well, or whose health needs had changed. We were told by a healthcare professional staff referred people appropriately and in a timely manner to the GP surgery. People had access to external health care professionals. We read in people's care plan they had involvement from the GP, district nurse, chiropodist, speech and language therapy team. One person had lost weight and we read staff had referred them to the dietician.

Requires improvement

Is the service caring?

Our findings

People had mixed views about how they were treated. One person said "Staff don't accompany me outside and I am unable to walk out on my own. I spend most of my time in my room, that's my choice. Staff were kind and knew what I need." Another person said; "I get treated like a piece of cloth." They said they had no choice. "If they (staff) wanted me up and dressed that's what I had to do." However one person said "Staff were caring and attentive."

People said they were not always made to feel as though they mattered. We saw staff standing around or sitting with people in lounges without talking to them. Most people were seen to be dozing or sleeping during the morning due to lack of interaction from staff.

People were not always treated with consideration by some staff who did not respond or react to certain incidents during the inspection. For example one person was urinating in the corner of the communal lounge room at lunch time but staff did not respond or react to this. Staff did not place some peoples call bells where they could be reached. Staff told us they did not have time "To do the finer detail."

Many people were not wearing shoes or slippers. One person had shoes in with no laces. We highlighted this to the provider and mid-morning saw a member of staff in a store room rummaging through a bin liner of shoes and slippers. We noticed one person had her name and room number written in marker pen on the corner of their blouse which was evident for everyone to see.

We witnessed one nurse not following best practice by carrying out wound care in front of another resident who had been brought into that person's room.

People were not always shown dignity. For example; we saw disposable clothing protectors were being used to protect peoples clothes, we saw the staff ask people if they minded having the cover, however the staff did not allow time for a full response and placed the clothing protectors in place. We observed a person attempt to enter another's room while they were receiving personal care. The staff in the room attempted to move the person, explaining this was not their room, they were not successful. The person entered the room used the sink and then left. We saw staff then guide the person to their own room. No other staff were in the area to offer support. We asked the staff if this was a frequent occurrence. Staff told us it did happen often. The person in the room receiving personal care was shouting at the other person to get out and was distressed by the incident.

Another person we spoke with told us their toilet was not fitted to the floor properly. We looked at this and saw it was loose on one side. They told us the toilet was too low and due to their physical health needs they were unable to get up from the toilet without help from staff who they would have to call for support. They told us this could take some time depending on what staff were available which did not promote their independence or uphold their dignity.

This meant that people had sometimes been left in undignified situations. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoke nicely to people, however there was little privacy in the home as residents were constantly wandering in and out of other peoples rooms.

We observed two members of staff walk by a person's room, while the person in the room was shouting and banging. The door was closed and there was noise coming from the room. Neither of these people stopped to enquire if the person needed any support.

Staff did not take the time to socially engage with people. We saw one member of staff standing, leaning up against the wall outside of the communal lounge area. Six people were sitting in the lounge with the television on, although most people were not watching it. The member of staff came into the lounge and sat next to one person for over 15 minutes but did not speak to them. During a period of 15 mins we observed people received no interaction from staff. Staff told us this was because people appeared to be asleep; however people were dozing through lack of stimulation.

People could make their own decisions about the care they received. We heard from people how they could get up or go to bed when they wished and those who preferred to eat lunch in their own room where provided with this. One person was asked if they would like to get dressed. They declined and staff respected this.

People were able to have privacy should they wish it. People told us they could return to their rooms and have

Requires improvement

Is the service caring?

time on their own if they wished it. One person told us they liked to spend time in their room. We saw people meeting with their relatives and moving to other areas of the home in order to have time alone.

Visitors were made to feel welcome. It was evident relatives where welcomed into the home and could call unannounced. We heard relatives talk to people and staff in a relaxed and friendly manner. One relative said “I can come here whatever time I like.”

We saw some lovely examples of caring care from staff. The staff spoke at a pace and tone which was appropriate for the person. The staff used each person’s name when speaking with them. It appeared staff cared about the people they were speaking to, however were unable to stop and spend time with them due to other duties they were required to undertake.

We observed some staff act in a respectful manner when interacting with people. During lunch service we observed a hoist being used to assist a person to sit at the table. We saw the staff speaking with the person reassuring them, checking they were ok during the lift we saw staff ensuring the persons’ hands were in the correct position to prevent them getting caught. We observed good communication and eye contact during this process. We observed the correct techniques and number of staff used during the process.

Requires improvement

Is the service responsive?

Our findings

One person told us they joined in on some of the activities, they said "I know the activities lady and they sometimes come to my room to speak to me, I know where they are if I needed them." Another person said "Occasionally I go to the lounge to join the singing, but I'm a loner and like being on my own." One relative said to us "It was a shame they didn't have music playing during the day (staff did put music on at lunchtime)."

Although activities were available there was a general lack of stimulation for people. We did not observe any specific activities suitable for people living with dementia and staff were not able to give us examples of appropriate activities. There was a lot of pictorial memorabilia around the home – photos, pictures, paintings on the walls, but nothing particularly sensory that people could pick and touch.

There were not a lot of activities available. People were sitting during the morning whilst staff were carrying out duties without any interaction. There were periods when no staff were present in lounge areas. People were sometimes socially isolated as staff did not have time to spend with them. During the morning we found people sitting in lounge areas with the television on, but no other stimulation. There was no information about daily activities provided for people in either written or any other form of communication. During the afternoon we saw one member of staff dancing with a person in the large lounge and several people sitting outside in the garden with a nurse and their relative, having tea and cake.

We recommend the provider considers best practice guidance to specific and appropriate activities for people living with dementia.

People could make complaints if they wished. We read the registered manager was currently dealing with two complaints from relatives and we read some actions which had been taken. One person said that they had raised concerns regarding being supported by male staff for their personal care. The person told us their issue was listened to and they only had support from female staff members after their concern had been raised

People felt their complaints were responded to in a timely way. A relative told us they had complained. A relative told us they had concerns however they we going to speak to their family members' case manager instead on this occasion. The relative told us they had, in the past raised issues of concern with the service that had been resolved, so they knew how to.

People's support needs and information about their lives were recorded in care plans. This included personal details such as the person's likes and dislikes. Relatives said they were involved in the development of care plans as well as their reviews. Staff told us any changes to a person's needs were discussed during their handover meeting and also written in a communications book which all staff signed to say they had read.

Staff said that they read the care plans to get to know people when they first started. They said each morning there was a handover between staff and a separate handover between the nurses and the registered manager to updated staff on people daily changing needs.

People and relatives were involved in the running of the home. Residents meetings were held to which relatives were invited. We read the notes from the last meeting which had involved discussion about staffing issues.

Good

Is the service well-led?

Our findings

The home demonstrated good management and leadership. People and relatives were generally happy with the service provided and the care they received, they said they were pleased that the registered manager had returned from their extended absence.

The registered manager clearly knew people as she was able to answer questions about people without having to refer to records. We observed the registered manager throughout the day interacting with people, relative and visitors. When the registered manager engaged with staff felt they respected her and listened to her.

Staff felt supported. Staff told us they felt supported by the registered manager and directors. Comments we received included, "I feel really supported." Another staff member said they felt supported by the registered manager and other staff. They said they had learnt so much working in the home. They said “I feel I could ask for help if I needed it and would be supported.”

Staff said the registered manager was out on the floor every day and felt they knew people. She added staff had regular supervision which was the registered manager’s way of ensuring they followed the ethos of the home.

Staff said that as part of their induction they also learnt all about the values and their ethos and aims. They told us senior staff checked they followed best practice. One member of staff told us they were happy working in the home and were provided with everything they needed.

Staff was involved in the running of the home. We read staff meetings were held regularly. This included a full staff meeting. We saw the notes from the last meeting which discussed care plans, mattress and the staffs understanding of mental capacity.

The provider carried out monthly quality assurance visits to the home. This was to ensure the home maintained a good standard of safety and care for the people who lived there. We saw actions which had been identified as a result of the last visit. For example, issues with the environment and particularly staffing. The nominated individuals showed us the future recruitment plans and action plans to ensure that the home recruited permanent staff to provide consistency in care for people.

The registered manager carried out a number of checks to make sure people received a good service and any issues identified were resolved. For example, we saw they provided monthly analysis of incidents and accidents, care plan audits, health and safety audits. One of these audits had identified that some people needed profiling beds instead of divan beds to support their independence. The registered manager showed us that the new beds had been ordered and they were awaiting delivery.

People, relatives and staff were asked for their feedback on the service. People and their relatives were happy with the quality of the service provided. We read the results of the last survey which showed people were happy with the staff and care, choice, home comforts and their quality of life. We read the satisfaction statistics of people had increased from the previous year. The registered manager provided us with compliments which had been left by relatives. One relative had stated they were "Very happy with the nursing care.”

All the policies that we saw were appropriate for the type of service, reviewed annually, were up to date with legislation and fully accessible to staff. The staff knew where they could seek further guidance and how to put the procedures into practice when they provided care.

The registered manager had ensured consistently that the appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely throughout the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured sufficient numbers of staff were deployed to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not support people's nutritional needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises was not always kept clean or properly maintained.**