Herefordshire Old People's Housing Society Limited

Hampton House Residential Care Home

Inspection report

Hampton House
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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

This was an unannounced comprehensive inspection carried out on the 18 April 2018, with a further announced visit on the 20 April 2018.

Hampton House Residential Care Home is a 'care home'. People in care homes received accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hampton House Residential Care Home accommodates up to 34 people within one adapted building, and provides care and support for older people. At the time of our inspection there were 34 people living at the home, some of whom were living with dementia.

There was a registered manager in post at the time of the inspection, who had been in place since February 2016. 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.

At our last comprehensive inspection of the service on 27 April 2016, the overall rating for the service was judged to be 'good.' At this inspection we have rated the service as 'requires improvement'.

During this inspection we identified two breaches of regulation. These were in relation to the people being deprived of their liberty for the purpose of receiving care without lawful authority, and effective quality assurance systems to drive improvements.

The management team lacked knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) process. Some people, who lacked mental capacity, were being deprived of their liberty for the purpose of receiving care without lawful authority. No DoLS application had been made to the appropriate local authority by the provider in line with the requirements of MCA.

Management and governance systems were not always effective. There was no clear policy or strategy in relation to the effective monitoring of the quality and safety of services. Care plans and risk assessments were lacking in information and did not always accurately reflect people's current needs. Monitoring charts were not always completed consistently. Information in care plans was sometimes contradictory and misleading about people's needs. There were no systems in place to identify the shortfalls we found in respect of the quality of documentation in order to drive improvement.

We could not be assured that the risk of developing pressure sores was being managed effectively for one person.

Incident and accidents forms were not always reviewed by management to ensure all appropriate action

had been taken.

People and their relatives told us staffing levels maintained at the home meant people's individual needs could be met safely, as staff were available at the times people needed them.

The administration and management of medicines was safe.

People and their relatives felt that staff had the necessary skills and knowledge to meet their needs.

People were supported by staff in a way that was kind, respectful and compassionate. Staff we spoke with demonstrated a good knowledge of the people they supported and the importance of encouraging people to be independent.

People told us there were sufficient activities to keep them occupied and stimulated.

People told us they felt comfortable to raise any concerns or complaints with staff or the management team. People were encouraged to share their experiences and make suggestions about services provided.

Staff consistently told us the registered manager and the management team, promoted an inclusive culture, which encouraged everyone to be open and transparent.

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.

Risks to people were not always managed safely.

People received their medicines as prescribed and safely.

People and their relatives consistently told us they or their family members were safe.

Staffing levels maintained at the home meant people's individual needs could be met safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people, who lacked mental capacity, were being deprived of their liberty for the purpose of receiving care without lawful authority.

People were provided with food and drink, which supported them to maintain a healthy diet.

Staff were trained to ensure they could deliver care that met people's needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

Staff treated people with respect and promoted their independence.

People and their relatives were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not accurately reflect people's current needs. There were inconsistencies in the quality of record keeping.

There was limited evidence of any advance care planning / recording of peoples' end-of-life care wishes in care files.

People were encouraged to pursue their interests and seek opportunities to broaden their experiences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Management and governance systems were not always effective.

Care plans and risk assessments were lacking in information and did not always accurately reflect people's current needs.

People were encouraged to share their experiences and make suggestions about services provided.

Hampton House 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 was an unannounced comprehensive inspection carried out on the 18 April 2018, with a further announced visit on the 20 April 2018. The inspection was carried out by two inspectors, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted in part by concerns raised by the local authority regarding the effective management of the service. The inspection was undertaken before the provider had been able to complete a Provider Information Return. 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.

Before the inspection visit, we reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority and Healthwatch for any information they had, which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

As part of the inspection, we spent time with people in the communal areas of the home and spoke with eight people who used the service and four visiting relatives. Some of the people at the home were living with dementia and therefore conversations were not in-depth. We spent time observing interaction between

staff and people who used the service. As some people were unable to speak to us, we used the Short Observational Framework for Inspections (SOFI) to help us understand their experiences of the support they received. We also spoke to a visiting health professional, and an external training provider, who provided us with information regarding their engagement with the home.

We reviewed a range of records about people's care and how the home was managed. We looked at five care records, medicine administration records, five personnel files and records related to the management of the service.

As part of the inspection, we spoke with the registered manager, a director for the provider, deputy manager, assistant manager, two senior members of care staff, four members of care staff, the activities coordinator, and two cooks.

Requires Improvement

Is the service safe?

Our findings

At the time of our last inspection in April 2016 the 'Safe' key question was rated as 'Good.' At this inspection we found improvements were required.'

At this inspection, we found measures had been taken to reduce the risks to people and ensure they were safe, such as the use of crash and sensor mats for people at risk of falls. However, although people had individual assessments of risk associated with their personal needs in place, some risk assessments lacked basic information. This included details of who developed and agreed the risk assessment, dates of implementation and review arrangements. There was no evidence of people's and their relatives involvement in the development of the risk assessment. The manner in which risk assessments documents were being reviewed and updated, together with hand-written notes on the assessment did not reflect good practice as it was difficult to determine the current level of risk the person faced.

For example. in relation to one person who was cared for in bed, staff had identified that they were at risk of developing pressure sores. However, the person's care file did not include any clear assessment of the seriousness of this risk. We saw the person's care plans did not clarify the arrangements for their repositioning, simply stating "care staff to turn me regularly throughout the day and night." The monthly pressure cushion check had not been completed since 26 July, with the year not recorded. We could not be assured that the risk of developing pressure sores was being managed consistently for this person.

Staff told us that on discovering an incident or accident had taken place, they would complete an incident log and submit to the management team. However, for a number of incident forms we reviewed, we found there was no evidence of a management review to ensure all appropriate action had been taken.

We saw Disclosure and Barring Service (DBS) and references were completed for new staff prior to starting work with people. A background check called a DBS check is a legal requirement and is a criminal records check on a potential employee's background. However, recruitment files we looked at were disorganised and did not always contain relevant information to demonstrate safe recruitment practices. For example, some records lacked proof of identification for new staff.

People and their relatives consistently told us they or their family members were safe living at Hampton House. One person told us, "I am quite happy here, everyone, including the care staff, listen if you want to say anything. I have nothing to complain about, I feel safe. We are well looked after." Another person said, "I do use my call bell, sometimes they come pretty quick and sometimes I have to wait, but usually no more than about 5 minutes I would say." One relative told us, "It gives me great peace of mind that my relative is here. I live a long distance away and don't get to visit often, I do ring every week and the home keep both my family and myself informed of any problems, changes in health or anything else really." Another relative said, "My relative has a walking frame to help them get about, there is always someone with them when they walk. They went to sit down on the chair in their room at home, lost balance and had a fall. It seems my relative is a lot better and they [staff] have helped with her mobility." A third relative said, "My relative feels safe living here. We feel they are safe. They overall health and well-being has improved since coming here."

People and their relatives told us staffing levels maintained at the home meant people's individual needs could be met safely. Staff told us there were sufficient staff on both days and nights to meet people's needs, and management were always prepared to help out if required. If there were any short falls, agency staff would be used. One member of staff said, "Staffing is good and so are the agency staff we use. Generally there are no concerns, and management are 'hands on' and are always happy to help." We saw staff had time to engage, sit and chat with people during our visit. We found there were sufficient numbers of staff on duty to enable them to care for people during our visit. We looked at staffing rotas and spoke to the registered manager about how staffing numbers were determined. Staffing levels was currently based on the registered manager's professional experience. They told us that they intended to consider the use of a dependency tool to assist in determining staffing levels at the home in the future.

The administration and management of medicines was safe. We saw staff checked each person's medicines with their records before administering them. We found all the medication records we looked at had photographs and people's allergies recorded. This reduced the risk of medicines being given to the wrong person or to someone with an allergy and was in line with current guidance. Records were accurate and completed correctly. This meant records evidenced that medicines were being given as prescribed. Staff told us that they received training and were subject of competence assessments by the provider. Medication audits were also undertaken to ensure medicines were administered safely. Some people were prescribed medicines to be given 'when required,' such as pain relief. Additional information was available for staff to help ensure they gave these medicines in a safe and appropriate way and when they were needed.

Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were stored as per legislation. We saw a controlled drugs register was signed and countersigned by staff confirming that drugs had been administered and accounted for. We undertook a stock take of controlled drugs and found them to be accurate. Where medicines required cold storage, daily records of temperatures were maintained.

Staff we spoke with on the day of our inspection were knowledgeable about how to raise concerns about the different types of abuse that could occur. Staff also confirmed they would not hesitate to raise any concerns with the management team if they were worried about the safety or wellbeing of a person. The registered manager understood their responsibilities in reporting any potential concerns in line with local safeguarding procedures. There was a provider safeguarding procedures and policy in place for the home, setting out types of abuse and roles and responsibilities of staff.

The areas of the home we visited were clean and smelt fresh. Relatives told us their loved ones and the home were spotlessly clean. One person told us, "The home is always very clean, they come and clean my bedroom regularly. They do all my washing and they put it away for me too." Another visitor told us they could not ever recall experiencing unpleasant smells and the home had always looked in a good state of repair and was always clean. They said the dining room, which was cleaned after every meal, was to a standard a lot of restaurants fail to reach.

There was good provision of personal protective equipment (PPE), such as gloves and aprons and hand washing facilities to enable staff to comply with good hand hygiene practice. We saw infection control and prevention advice was available to staff with posters displayed in toilet areas.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the management team lacked knowledge of the MCA and DoLS process. Providers and their staff must understand and work within the requirements of the MCA, whenever they work with people who may lack the mental capacity to make some decisions. We found some people, who lacked mental capacity, were being deprived of their liberty for the purpose of receiving care without lawful authority. No DoLS application had been made to the appropriate local authority by the provider in line with the MCA.

Were a person lacked mental capacity to consent to care, including depriving them of their liberty, providers must follow a best interest process in accordance with the MCA, including DoLS, where appropriate. We saw no reference to, or examples, of mental capacity assessments or best-interests decision-making in relation to people's care. This included the decision to care for people in their beds. The deputy manager showed us 10 (generic) mental capacity assessments that had been completed to guide the management team as to whether a DoLS application should be made, however these were not decision-specific. The home lacked any suitable guidance such as an up to date MCA / DoLS policy or procedures for staff.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager acknowledged their short comings in this area and told us they had arranged, and we saw, participation in MCA training on the second day of our inspection visit. The registered manager then told us, after the inspection visit, that they had submitted three DoLS applications to the local authority with appropriate statutory notifications to CQC. No one we spoke with during the visit expressed a wish to leave the home unaccompanied.

Throughout our visit, staff were observed seeking consent from people before undertaking any routine tasks. They explained to people what they wanted to do, and ensured people were happy before proceeding with any support. They also provided reassurance while undertaking the task. However, 'records of consent' had not always been clearly recorded in people's care files. Do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decisions had been appropriately recorded in people's care records where applicable.

People and their relatives felt that staff had the necessary skills and knowledge to meet their needs. One person told us, "The carers are absolutely excellent and their patience is incredible, they always seem to know the right thing to do and the right thing to say. Some of the other residents shout at them and they

cope very well." One relative said, "Staff all seem confident and knowledgeable." We spoke to a new member of staff who told us they were currently on their induction programme. They had previously worked in care and following initial training in moving and handling they were now 'shadowing,' which meant working alongside more experienced staff before being able to work independently. All new staff were required to complete the Care Certificate, which is a nationally recognised qualification in social care.

The registered manager told us that all staff were now being encouraged to complete the Care Certificate, unless they had another nationally recognised qualifications in social care. Staff told us they received regular refresher training, which included safeguarding, first aid, fire safety, infection control and prevention. A number of staff had undertaken other nationally recognised qualifications in social care. In addition to training, staff told us they received regular supervision meetings with management to receive feedback on their work performance and identify any additional support or training they required. The registered manager told us the provider was about introduce an annual appraisal to support staff development.

People's dietary requirements, likes, dislikes, and allergies were known by staff. One person told us, "The food is very good, there is nothing I don't like. You can have whatever you want for breakfast, there is soup, cakes, sandwiches and fruit at teatime and a cooked meal for lunch. There is plenty of tea and drinks and biscuits throughout the day." Another person said, "Food is good, plenty of it and plenty of choice." One relative told us they felt the home was far superior to a previous one their relative had stayed at and that the food was very good. They visited often and were able to have a meal with their loved one.

We observed the lunch time experience and saw food was served to people individually in the place of their choice. The tables were laid with napkins and table cloths, cutlery, condiments and glasses. There were fresh flower table decorations. Staff were present throughout providing individual support to people when they required it. Staff offered to cut up food for people and asked them whether they wanted any sources or drinks. Extra food was also offered, which some people accepted. The atmosphere was calm and organised with people chatting and discussing the weather and about going outside for a walk and a sit down in the garden after lunch. Bowls of fruit were available throughout the day, as well as hot and cold drinks and biscuits were offered regularly to people.

Hampton House is an adapted older building, where communal areas were spacious and light and there was some signage features that would help to orientate people living with dementia. People could choose whether to spend their time either in their rooms or with other people in the main lounges. People were supported to access the garden areas by staff during our visit. Relatives and visitors were able to spend time with their loved ones in private or in one of the communal areas.

We asked people about how they were supported to access external health services. People and relatives confirmed health care professionals visited regularly with the GP routinely in attendance on a weekly round. One person told us, "The doctor came yesterday to see me and has given me a clean bill of health." A relative told us their loved one had not been very well recently and that staff had called a doctor out and kept them us up to speed with any developments. We saw evidence in people's care files of the involvement of community healthcare professionals, such as district nurses, GPs, opticians and chiropody. We also saw that changes had been made to people's care plans to reflect guidance from external health care professionals. For example, a person's moving and handling plans had been changed in response to professional advice received.

A visiting health care professional told us they had been visiting the home since 2011 and undertook a weekly round. They described staff as "couldn't be more caring," who supported people and their relatives very well. They told us staff responded well to instructions and were very pro-active in monitoring people's

health. They also said they had no concerns about the standard of care provided.

Good

Is the service caring?

Our findings

People were supported by staff in a way that was kind, respectful and compassionate. People and relatives told us they were happy with the standard of support they received and spoke positively of their relationships with staff. One person told us, "The [staff] here are wonderful and they all work so hard. I felt better being in here and my family live nearby. This is my home." Another person said, "There is permanent staff most of the time, who are wonderful and pleasant." A third person said, "The carers are all very kind and caring, they help us with all sorts of different things, nothing seems to be too much trouble and they all appear to know what they are doing." One relative told us, "The staff are very sensitive, they tuck our relative in at night time." Another relative said, "My relative is quite happy here I believe, they are very happy and talkative today which is good to see. I have no concerns."

We saw staff engaging with people in a compassionate and caring manner throughout our visit. People were relaxed, calm and were at ease with staff who supported them. Staff took time to speak and chat with people as they performed various tasks. There was laughing and joking and affectionate interaction. We saw one person being transferred from a wheelchair to an armchair with the support of two care staff. Staff were very supportive throughout the transfer. They discussed where the person would like to sit and they made sure they were comfortable upon completion of the task. One regular visitor to the home told us the person to staff interactions that they had witnessed, were considerate, dignified and of a standard that other homes should aim for. They described staff as appearing to enjoy their jobs and genuinely gave their all to people who lived at the home.

People and their relatives confirmed they were involved in making decisions about their care and were always involved if changes were required. People also told us the care provided reflected their or their relative's wishes, and were satisfied with the support and opportunities they and their family members had to express their views.

People told us that staff treated them with respect and dignity at all times. One person told us, "The carers always knock before coming into my room, they are very respectful of my privacy and my dignity. There was a carer, agency I think, who helped me last night with personal care and waited just outside until I was ready, they was very helpful." One relative said, "I am more than happy my relative is here, they are a lot happier, carers are all friendly and respectful of their dignity. I leave the room if they need to sort anything out and they always close the door and I can hear that they are doing things the right way."

Staff we spoke with demonstrated a good knowledge of the people they supported and the importance of encouraging people to be independent. We saw staff encouraging people to retain their independence, when mobilising or eating and drinking for example. One member of staff told us, "We try to promote people's independence and encourage them in respect of personal care and walking. It improves their well-being."

Requires Improvement

Is the service responsive?

Our findings

On the whole, people's care was delivered to meet their individual needs. Staff were able to demonstrate a good understanding of people's needs. However, this was not clearly reflected in the care files we looked at. Care plans lacked basic information and there was a lack of any evidence of the involvement of people and their families. It was difficult to determine the current and most up to date needs of people, due to the way care plans had been hand written. This was potentially confusing for staff, especially agency staff who did not know people well. For example, one person's social support care plan did not reflect the fact the person was now being cared for in bed. In discussions with the deputy manager, they indicated that another person had a poor appetite, however the person's nutritional care plan did not make this clear.

The information recorded in people's care files was sometime confusing and contradictory. For example, one person's initial assessment form recorded "No problems with communicating. I have problems verbally communicating," and "Speech no problems. I am unable to get words out properly." Some re-positioning chart records we looked at indicated that some people were not receiving consistent support in line with their care plan. We saw gaps in people's weight charts without any clear rationale for these omissions. There was a lack of clear, recorded rationale for why people were being cared for in bed. The manner in which reviews of certain care documentation had been recorded indicated this was not a meaningful review process as a "reviewed (date)" was simply repeated. The registered manager was receptive to the issues we had identified with the quality of care plans and told us they would be shortly introducing a new system of care plan documentations, which they believed would address the concerns we identified.

At the time of our inspection visits, we were told that there was one person at the home receiving palliative care. However, we saw very limited evidence of any advance care planning / recording of people's end-of-life care wishes. The registered manager told us they were in the process of implementing a new End of Life Care Plan. The registered manager also told us that people were supported in making decisions, and there was constant involvement from the GP's and district nurses team. They discussed people's last wishes and involved families in this process. The home worked closely with the staff from the palliative care team, including Macmillan and community nurses, religious/spiritual advisors and other representatives such as an advocate and any legal guardian. However, these discussions and decisions were not recorded in a consistent way for staff to follow.

The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. The registered manager told us they had a limited insight into the Accessible Information Standard. However, they told us they had the facilities to produce information in alternative accessible formats if required to meet people's information and communication needs. For example, alternative format other than standard print and large print was offered if required. The provider utilised talking books and there was a talking local newspapers group. The provider was also considering having their brochure and any other relevant documentation converted into Braille and/or CD format. Lip reading was another way of understanding and supporting some people. People were also supported with pictures, diagrams, and symbols to aid communication.

The provider told us to their knowledge they had not cared for a person from the lesbian, gay, bi-sexual and transgender community (LGBT). However, they were confident that staff could provide person centred care to meet peoples' specific needs and support people to live the lives they wished. The registered manger told us they promoted equality, diversity and human rights (EDHR), which also involved staff and enabled them to fulfil their potential, and had recently updated the provider's policy to reflect this. EDHR issues would also be included in staff supervision & appraisals. One member of staff told us in response to a question about LGBT needs, that it wouldn't make any difference as they would support people to live their own lives, which would also include their religious needs.

The provider employed an activities coordinator to organise and undertake social and recreational activities with people on a group and one-to-one basis. The activity coordinator was employed for 10 hours each week, which some staff felt was insufficient to fully meet the needs of people. However, people told us there were sufficient activities to keep them occupied and stimulated. One person said, "There is a band that comes in and plays, and a lady comes and sings too. We have exercises we do." Another person said, "I get the paper delivered every day and I do the crosswords, I knit and sew and I like gardening. I do usually go on trips if its offered, sometimes we just go for a ride round, we go to garden centres and on shopping trips." A third person told us, "I like to do jigsaw puzzles and crosswords, this afternoon I am going for a walk around the grounds as it is such a lovely, warm day. There is a member of staff [activities coordinator] who comes in and reads to us three evenings a week. We have armchair exercise classes if we want to partake, we had a quiz yesterday that was very entertaining."

People told us they felt comfortable to raise any concerns or complaints with staff or the management team. There was a complaints system in place, and information about how to complain was readily available. People were also able to raise concerns and provide feed-back at 'resident and relative meetings,' which were then addressed by the registered manager. A suggestion box was also available in the reception area. One person told us, "We do get asked occasionally if we are happy and satisfied and if we have any suggestions or complaints." The registered manager told us that families and people were regularly consulted about their needs, however there was no evidence of such consultation in any of the care files we looked at.

Requires Improvement

Is the service well-led?

Our findings

Management and governance systems were not always effective. There was no clear policy or strategy in relation to the effective monitoring of the quality and safety of services by both the registered manager and provider. The management team lacked knowledge of the MCA and DoLS process, and some people, who lacked mental capacity, were being deprived of their liberty without lawful authority.

Care plans and risk assessments were lacking in information and did not always accurately reflect people's current needs. The manner in which risk assessments and care plans were reviewed did not reflect good practice and made it difficult for staff to establish the current level of risk and needs of people. Monitoring charts were not always completed consistently. Information in care plans was sometimes contradictory and misleading about people's needs. One member of staff confirmed that there was no formal process of involving people and their families in determining and reviewing their care needs. Some recruitment files we looked at were disorganised and did always contain relevant information to demonstrate safe recruitment practices. There were no systems in place to identify the shortfalls we found in respect of the quality of documentation in order to drive improvement.

We spoke with the registered manager and provider who acknowledged our concerns and were receptive to the need to take immediate action for some of the failings we found. The provider told us that a number of quality assurance checks were undertaken, however, these were not always recorded. The registered manager confirmed their intention to introduce new care file documentation imminently, which they believed would address the issues relating to the quality and accuracy of people's car plans and risk assessments.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this was because the provider had failed to effectively assess, monitor and improve the quality and safety of services provided and ensure records were up to date and accurate .

We saw evidence of regular fire safety checks being undertaken, together with medication audits and competency assessments of staff. People were encouraged to share their experiences and make suggestions about services provided. People responded to an annual 'resident surveys,' where suggestions and concerns were addressed by the registered manager. Resident and relative meetings were also held. People told us that staff and management were always available and happy to address any issues they raised.

The home endeavoured to learn and had implemented new strategies following specific incidents. For example, sensory equipment had been provided for people at high risk of falling, and a new falls reporting format had been introduced for staff. To address short term memory loss amongst people, a monthly memory club had been established. The home also attended local authority forums to reviewing working practices and improve care practice as required.

Staff consistently told us the registered manager and the management team, promoted an inclusive culture,

which encouraged everyone to be open and transparent. Staff felt confident that they would be listened to if they raised any concerns the service or working practices. They were aware of the provider's whistleblowing policy and told us they would follow this. One member of staff told us, "We have staff meetings and discuss any issues and concerns, even training needs. I do feel valued and supported. The management team are very supportive, I have no concerns and believe it is a nice home."

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that we had received all the required notifications in a timely way from the service. We saw the 'ratings' from the last inspection visit were on display in the reception area of the home in line with the requirements of regulations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Some people, who lacked mental capacity, were being deprived of their liberty for the purpose of receiving care without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of services provided and ensure records were up to date and accurate.