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Langdale Residential Home

Inspection report

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West Yorkshire
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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?	Good
Is the service well-led?	Requires improvement

Overall summary

Langdale Residential Home provides personal care for up to 19 older people. The home is situated in the Bierley area of Bradford. The accommodation is provided in mostly single rooms with a small number of double rooms. Some rooms have ensuite facilities. The home has a range of communal areas including lounges, dining room and gardens.

This was an unannounced inspection which took place on 27 October 2015. On the date of the inspection there were 15 people living in the home.

A registered manager was in place. 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 told us medicines were appropriately managed and we found people received their medicines at the time they needed them. However we found on a number of occasions stock levels of medicines did not tally with

Summary of findings

what was recorded within records. This meant we could not confirm people had received their medicines. In addition, the number of tablets administered to people and stock levels were not always recorded.

This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were sufficient to ensure people were appropriately cared for and supervised. Staff had time to engage people in conversation as well as delivering care and support. Safe recruitment procedures were in place to ensure new staff were of suitable character to care for vulnerable people.

People told us they felt safe in the home and staff understood how to identify and act on concerns.

Risks to people's health and safety were well managed. Risk assessments covered areas such as falls, mobility and any specific risks such as diabetes. Staff understood these assessments and how to protect people from harm.

The home was not consistently acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Although some DoLS applications had been made, possible deprivations of others people's liberty had not been considered.

People had access to a range of healthcare professionals to help ensure their healthcare needs were met.

Staff received a range of support and training and told us it was effective in giving them appropriate skills to care for people within the home. People told us staff were knowledgeable about them and their individual needs.

We received mixed feedback about the quality of the food with some people saying choice and quality could be improved. Nutritional risks to people were generally well managed with snacks and drinks provided to people throughout the day.

Staff displayed a kind and caring attitude towards the people they were caring for. People all spoke positively about staff team and said staff treated and cared for them well. Care was delivered by an experienced staff team who knew people well and their individual likes, dislikes and preferences.

People had a range of care plans in place which demonstrated a personalised assessment of their needs had been carried out. Through our review of records, speaking with staff and people who use the service we concluded people received appropriate care that met their individual needs.

A programme of activities was delivered by the activities co-ordinator who worked in the home four days a week.

A system to manage and respond to complaints was in place.

People and staff spoke positively about the way the home was run. There was a friendly and inclusive atmosphere within the home.

At the last inspection in June 2014 we identified concerns with the way the service assessed and monitored the quality of the service. At this inspection we found some improvements had been made for example in the way quality surveys and some audits were conducted. However some audits were still not sufficiently robust for example medication audits. Clear action plans were not always in place where audits had identified issues to provide a structured approach to improvement.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Medicines were not consistently safely managed as appropriate arrangements were not in place to account for all medicines.

People told us they felt safe and staff demonstrated a good awareness of how to keep individuals safe.

Staffing levels were sufficient to ensure people received appropriate care and support.

Requires improvement

Is the service effective?
The service was not always effective.

The home was not consistently acted within the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated a good knowledge and understanding of the people they were caring for. Staff received regular training, support and supervision.

Nutritional risks to people were well managed. People had access to a range of health professionals to help ensure their healthcare needs were met.

Requires improvement

Is the service caring?
The service was caring.

People were treated with dignity and respect and spoke positively about the kind and friendly attitude of staff.

People received care from people that understand their individual likes, dislikes and preferences. People had their views and choices listened to.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed and personalised plans of care put in place. Staff understood these plans of care and we saw evidence they were followed.

An activities co-ordinator was in place who delivered activities and provided

social companionship for people.

Good

Is the service well-led?
The service was not consistently well led.

People and staff both spoke positively about how the manager was run. Care was delivered in a friendly and inclusive environment.

Requires improvement

Summary of findings

Improvements were required to some of the systems of audit and quality assurance to ensure a consistent and high quality service was maintained.

Langdale Residential 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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked whether improvements had been made following our previous inspection in June 2014 where we identified a breach of regulation relating to "Assessing and Monitoring the Quality of the Service Provision."

The inspection took place on 27 October 2015 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in the lounge and communal areas of the home. We spoke with six people who used the service, three care workers, the cook, the registered manager and the deputy manager, We looked at a three people's care records and other records which related to the management of the service such as training records and policies and procedures.

On this occasion, we did not ask 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. However we reviewed all information we held about the provider.

Before the inspection we contacted the local authority to get their views on the service

Requires improvement

Is the service safe?

Our findings

People told us they received their medicines on time. People had medication profiles in place which described the support they needed in taking their medicines. Most medicine was administered from monitored dosage systems. We saw this system was managed appropriately and people received their medicines at the times they needed them. For example some people required their medicines early in the morning and systems were put in place to ensure night staff administered these medicines. .

Medicines were administered by senior staff who had received training in the safe management of medicines. Answers given to us by the staff member administering medicines demonstrated a good knowledge of people and their medicines. We observed the medicine round and saw medicines were administered in a pleasant and friendly way by staff. Staff asked people's consent before giving them their medicines.

We found medicines were signed for at each administration on a medicine administration record (MAR) chart. MAR charts were well completed. We checked a sample of monitored dosage boxes and MARs which showed people had received their medicines as prescribed.

Although monitored dosage medication was managed well, we found a lack of accountability for people's boxed medication. Where people were prescribed one or two tablets, for example paracetamol for pain relief, although we saw staff asked people how many tablets they wanted, the number administered was not recorded on the MAR. This lack of appropriate record keeping meant that it would not be possible to accurately review the dose of medicine these people had received. This also meant that auditing and accountability of stock levels for these medicines was not possible.

We found other instances of stock levels not being recorded on MARs and where they were they did not balance with the number of medicines in stock. In some of these instances, the number in stock was more than the records which suggested people had missed doses of medication.

The provider had a medicine management policy in place but it was not comprehensive. The policy was not based on the National Institute for Care and Excellence (NICE) guidelines. As such it was missing some required sections. For example although we were told no person was receiving their medicines without their knowledge (covertly), the service's medicine policy did not state the procedure for managing covert medicines should the need arise.

When medicines were prescribed to be given as needed there were no care plans, (PRN protocols) in place to give guidance on the frequency or circumstances when these medicines should be administered. This meant there was a risk people would not be consistently offered their as required medicines when they needed them.

This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate arrangements were in place for the ordering, and disposal of medicines. Medicines were stored securely within the medicine trolley with staff taking care to ensure it was not left unsecured at any time. There were no controlled drugs at the home on the day of the inspection although appropriate storage and recording arrangements were in place.

Where topical creams were applied records of this was kept within people's bedrooms.

People told us they felt safe living in the home and had no concerns or worries. For example one person told us "Oh we're very safe here. I've never felt frightened." Nobody told us they were treated unkindly or ever spoken to rudely by staff. People told us they could raise concerns and felt that they could talk to any member of staff or the manager and they would be listened to.

Staff and management had a good understanding of safeguarding matters and how to identify and act on allegations of abuse. Staff had received training in safeguarding. This gave us assurance the correct procedure would be followed to investigate concerns and keep people safe.

Risks to people's health and safety were managed appropriately by the home. Staff were aware of the need to look out for and remove hazards from the environment, for example we observed them ensuring routes were free of trip hazards and putting walking aids and wheelchairs well out of the way when not in use. Staff took the time to help support people to mobilise throughout the home to reduce the risk of falls. The home had assessed risks to each

Requires improvement

Is the service safe?

individual and people had a range of risk assessments in place for example covering pressure area care and mobility. We found staff had a good understanding of the risks which each individual presented. For example staff could confidently describe who needed thickeners in their drinks, and who had their meals pureed to reduce the risks to these people. Appropriate plans were in place to control the risks associated with diabetes. Where falls risks were identified, falls care plans were put in place and control measures such as assistive technology used to help keep people safe.

Personal evacuation plans were in place for each resident. These were kept centrally, as well in care plans so they could be accessed promptly in an emergency.

Accidents and incidents were recorded and investigated. We saw changes to plans of care were made following incidents demonstrating preventative measures were put in place to help keep people safe.

We found there were sufficient staff to meet people's needs. On the day of the inspection, there were 15 people living in the home. Three care workers were on shift during the day and two at night. In addition there were ancillary staff such as the cook, cleaner, an activities coordinator and a deputy and manager who had supernumerary time to complete management duties. All the staff we spoke with told us there were enough staff to attend to people promptly and meet their needs. Our observations of care and support showed that when people asked for assistance staff promptly provided care. There was suitable supervision of communal areas. Charts of daily care were complete and provided evidence that timely care was delivered for example regarding pressure relief. Most people told us there were enough staff. For example one person told us "There seems to be enough. They do the best they can" and another person told us "Yes, there are enough. If I ring at night I wait three or four minutes." We looked at rotas which showed the planned staffing levels were consistently maintained.

Safe recruitment procedures were in place to ensure staff were of suitable character for their role. This included ensuring a Disclosure and Baring Service (DBS) check was undertaken on potential employees and obtaining references from past employers. New employees were required to complete an application form and attend an interview with the aim of ensuring they were suitable to work with vulnerable people.

The home looked clean and we did not encounter any unpleasant odours during our inspection. People told us they had no problems with cleanliness within the home. For example one person told us "I think it's very clean. My room is cleaned every day I think. I wouldn't go in it if it were dirty."

The premises was generally safely managed. Adequate communal areas were in place which included two lounges and a dining room. Radiators were covered to prevent scalds from hot surfaces and restrictors were in place on windows to reduce the risk of falls. However there were several areas that required decoration, many rooms had shabby peeling wallpaper and carpets were worn in some areas. Maintenance and checks were undertaken for example on lifting equipment, electrics and gas. Thermostatic mixing valves were in place to help prevent scalds from hot water, however the home was not currently undertaking checks on water temperatures to check the valves were being regularly checked. The manager agreed to ensure action was taken to document these in the future.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We spoke with the manager about Deprivation of Liberty Safeguards (DoLS). We found two DoLS applications had been made for people that lacked capacity, with the manager focusing on those who were at high risk, for example one person who regularly asked to leave the premises. These applications were currently with the supervisory body awaiting assessment. However we found the restrictions and supervision placed on other people living in the home had not been adequately assessed to determine whether any other deprivation of liberties were taking place and authorisations were needed. There were a number of people who were subject to continuous supervision and monitoring for example through the use of pressure mats. The manager agreed to take immediate action to ensure this assessment was undertaken and where appropriate further applications made.

People reported no restrictions on the freedom. For example one person told us “I go out with my family whenever I want.” People said they were asked for consent with regards to their daily lives and we saw this was the case in the interactions we observed. Care plans were written with a focus on promoting choice amongst people who used the service. We observed people’s consent was asked before any intervention, in a very informal and friendly way

However we found where care and support decisions were made on behalf of people without capacity for example around decisions relating to the provision of bed rails and pressure mats there was a lack of documented evidence that decisions had been made within the legal framework of the Mental Capacity Act (MCA).

We recommend the provider consults appropriate guidance to ensure it consistently acts within the legal frameworks of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Where people displayed behaviours that challenged we saw staff were able to intervene promptly to reduce anxieties. They showed skill, patient and kindness in redirecting people to avoid potential problems.

Everyone we spoke with told us they felt staff knew how to look after them and that for the most part care was delivered by a consistent group of staff. We found an established staff team was in place many of which had been working with the provider for a number of years. This helped ensure care was delivered by familiar faces with established skills and knowledge.

Staff told us they received regular training. We saw training had been provided in subjects which included first aid, safeguarding, end of life, moving and handling and pressure area care. The manager and deputy had received bespoke training in Mental Capacity Act (MCA) and safeguarding to help provide enhanced skills in these areas.

The registered manager told us they had made arrangements for all new and current staff to complete the Care Certificate. They explained they wanted everyone to complete this to refresh skills and ensure all staff had the same core skills and knowledge. We saw new staff and night staff were currently enrolled on the Certificate with the day staff due to start shortly .

Staff told us they felt well supported. We saw they received regular supervision and appraisal. This covered any worries or concerns they had and developmental needs for the future.

Food was prepared by a dedicated cook each day. There was a choice of cereals, toast or a cooked option for breakfast each day. A choice of sandwiches was offered for lunch with the main meal provided in the evening. One staff member explained how they now provided the main meal in the evening because they found people ate more later in the day and it suited people’s routines better.

The home was flexible in the provision of meals, for example people got up between 6am and 11am and breakfast was prepared individually for them at the time that suited their needs.

People provided mixed views on the quality of the food. One person told us "It's OK. It's nice, If you're not keen on what they have they'll find something else. There's not really a choice otherwise. The food is warm and I think the

Requires improvement

Is the service effective?

quality is OK because I'm a fussy person." Another person told us “It's not varied enough. It's mostly lumps of chicken. There's no choice but you can't expect five star treatment. I'd like the food to be a bit more spicy, a bit more taste." A third person told us "It's alright but I've only a very small appetite. We all get the same but it's not the same every day."

The menu was rotated over a four week cycle and changed about three times a year, giving people a variety of food over the course of a month. There was only one main meal choice each evening, however people told us that if they didn’t like it they home would happily prepare something additional.

People told us there were plenty of snacks and drinks provided through the day. For example one person told us “Oh yes, there's plenty of snacks - anytime you want something. You can get a drink when you need one." Another person told us "Yes, if we ask for a drink they'll bring one. You don't have to wait until they come round." We saw this was the case with people being offered drinks and snacks through the course of our inspection and staff were responsive to people’s individual requests for drinks.

We found some elements of the mealtime experience could have been improved. For example the dining room tables were not set at breakfast and no condiments were on the table at lunchtime. There were no pictures of meals or any menus in the dining room and people were not offered a visual choice of what was available at the meal time. No fruit was offered to people during the course of the inspection to promote healthy eating.

Nutritional risks were appropriately managed by the home. People were weighed monthly or more frequently where required. Where this was not possible other monitoring techniques such as taking arm measurements were undertaken. Staff demonstrated a good awareness of how to assist those at nutritional risk such as through the provision of supplements and snacks between meals. Where people were at risk of poor nutrition we saw food and fluid charts were maintained. We examined these for two people and saw they were generally well completed demonstrating staff were offering people food and drink throughout the day. However there was no target fluid/food intake for these people and as such evaluation of whether they were receiving enough nutrition or hydration to meet their individual needs was not possible.

People told us they could discuss any health issues with staff and could see a doctor or other health professional if they needed to. People said that staff would organise either a visit to the home or an appointment. Care plans were in place to help meet people’s healthcare needs. The home operated the Pressure Ulcer Safety Cross, an initiative run by the local NHS to help monitor and investigate any skin integrity problems within the home. We saw a low instance of pressure sores and appropriate preventative measures in place such as providing equipment and other pressure relief indicating care in this area was appropriate.

Some adaptions had been made to assist people living with dementia. For example clear signage was in place on bedroom doors and communal areas to help direct people around the home. Further improvements could be made for example through use of more pictorial displays to help people choose activities and food.

Good

Is the service caring?

Our findings

There was a pleasant and friendly atmosphere in the home and we observed lots of good interactions between staff and the people living there. Staff were observed talking to people about their family lives, their working lives and asking them their opinions about things as well as delivering care based tasks. This helped meet people's social and emotional needs.

Care plans focused on ensuring dignity was respected whilst delivering care and support. All the people we spoke with told us that they were treated with dignity and respect. For example one person told us "I would say that they always do. They've never been unkind either." Another person told us "We're always treated very nicely." Everyone told us the staff respected them and respected their privacy, for example when helping to dress. Another person told us "They sweat their little socks off for us. I feel cared for and people are kind. I'm looked after physically and mentally. I'm happy here." This was confirmed in the interactions we observed. For example staff spoke kindly and patiently to people and shared jokes with them. People told us they were happy with the care provided by the home. They told us they would recommend the service to others.

Overall, we found the provider and the staff were caring. However we identified one isolated incident where a person was not treated with dignity and respect. We saw staff using one person's bedroom as an airing room to dry washing, which took up considerable space within the person's room. This meant the person couldn't go back and make use of their room in any way they may wish to until the staff had removed everyone else's ironing. We raised this with the manager who took prompt action to address.

We saw staff were visible and able to offer support to people when they needed it. For example we saw one person upset another person living within the home. Staff spent time with the person settling them down and made them feel comfortable in a very supportive and caring way. Where people became anxious or distressed staff acted promptly and appropriately.

We saw staff promoted people's independence where possible, for example encouraging one person to be involved in assisting in the preparation of drinks for others.

Everyone said they felt they were as independent as they could be and were supported to be independent by the staff. For example one person told us "I feel I can be fully independent. If I need any help, they're there."

An established staff team worked at the service and as such as they had developed strong relationships with the people they were caring for. Staff confirmed this for example one told us "We are very close to the people who live here. We see them as our extended family and we feel it when people don't get visitors." Our observations of care and support and discussions with staff revealed staff had a good knowledge of people and their individual likes, dislikes and preferences. Everyone said the staff knew them well and knew their likes and dislikes.

Care plans were heavily personalised which indicated they had been completed in conjunction with people by knowledgeable staff. Care plans contained detailed information on how to help communicate with people and talk appropriately with them. We saw these plans were followed with staff adapting communication techniques dependant on who they were taking to.

People told us their friends and relatives could visit the home whenever they liked and they reported no restrictions on visiting times.

People reported they had their choices respected and they felt listened to. For example one person told us "Yes, they do listen and they'll do something about it too." People reported that day to day life was based on their personal preferences rather than routine. For example one person told us "I make all my own decisions." People said they could get up and go to bed when they wanted to. For example one person told us "I can get up and go to bed when I like. I can stay up all night if I want" Another person told us "There's a few of us like to watch a late film. I'm often up late." A keyworker system was in place which meant people had a named contact to discuss any issues with. Care plans focused on offering people choice and listening to them for example what clothes to wear and what they wanted to do.

Observation showed staff asking people their views on a variety of things such as, the food, what television they wanted to watch and what pastime would they like to take part in. Staff listened to their choices before taking action to ensure needs were met.

Good

Is the service responsive?

Our findings

Care records demonstrated that people's needs were assessed and person centred care plans put in place to help meet people's individual needs. Care plans contained a good level of personalised information, for example specifying the individual tasks people could do for themselves and the specific nature of the support required. A range of care plans were in place for example covering, mobility, personal care, continence and pressure care. Specific care plans were in place where needed for example around diabetes care and behaviours that challenge. Care plans to assess and help meet people's social needs were in place.

People told us their care needs were fully met, for example one person told us "I think it's a high standard of care. My needs are catered for." Staff we spoke with demonstrated a good understanding of how to deliver appropriate care to the people we asked them about and we saw examples of care being delivered in line with care plans. This demonstrated people were receiving appropriate and individualised care.

We looked at comments recorded by external health and social care professionals as part of annual reviews of people's care. Comments recorded spoke positively about the standard of care and support provided.

Care plans were reviewed monthly with any updates written in the evaluation section of the care plan. Although we found most care plans were up-to-date and relevant we found one person who was now cared for entirely in bed, however their care plan had not been properly updated to reflect this. We did not find this impacted on the person as staff were clear as to the care they needed to deliver. However it was a potential risk should an unfamiliar care worker read the care plan. The manager agreed to make the necessary changes. In addition, some people had had limited information recorded on their life histories. Although we concluded staff knew people well, the provision of this information would help ensure consistent care and support from unfamiliar or new staff.

Review of daily records showed people received regular care in line with the frequency of their care plan for example with regards to bathing or showering. We found people were clean and neat indicating that staff met their personal care needs.

Daily handovers between care shifts took place. Clear information was recorded which helped staff brief each other on people's care needs and any changes. This helped provide responsive care.

An activities co-ordinator was employed to ensure the provision of a range of activities to help meet people's social needs. We saw they arrived at 11am and asked people what they wanted to do that afternoon. The co-ordinator spent time with people in their rooms to talk to them on an individual basis to ensure they were not overly isolated. The activities co-ordinator told us they did a range of activities which included reminiscence work , baking, gentle exercise and organising film afternoons although there was no formal plan in place. Arrangements were in place to help meet people's spiritual needs for example through visiting a church. We observed activities and saw a friendly atmosphere with people becoming involved and animated, having conversations and laughing with each other.

Information was displayed on how to make a complaint and there was information present within the service user guide present in people's rooms. Nobody we spoke with told us they had cause to complain. Staff we spoke with demonstrated a good understanding of how to deal with any complaints. They told us that people were generally happy and no complaints had recently been received. Complaints records showed no complaints had been made in the last 12 months indicating a high level of satisfaction with the service.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in place. Since the last inspection a deputy manager had been appointed with supernumerary time to assist in management duties. For example to assist with the oversight of care plans and quality assurance.

We found the provider had submitted required notifications to us and responded promptly when we asked for additional information or evidence.

At the last inspection in June 2014 we found the provider was not fully assessing the quality of its service provision. We issued a compliance action and asked the provider to make improvements.

At this inspection we found some improvements had been made. For example surveys from people and their relatives were now appropriately analysed and displayed. There was an increase in the number of audits, care plan reviews were now up-to-date and analysis was undertaken on incidents and accidents.

.A range of audits were undertaken. For example care plans were audited monthly as part of the review process where plans of care were evaluated and any incidents or accidents to the person included in this process. However further improvements were required to ensure good governance

Audits were undertaken in areas such as health and safety and infection control. However where defects had been identified such as with the premises, a clear action plan was not always put in place with defined responsibilities. This meant there was no clear plan to address these issues and ensure continuous improvement.

Systems to monitor whether care and support was being delivered in line with policies required improvement as we found some examples of policies not being fully followed. . For example the Mental Capacity Act (MCA) policy stated that each person will have a written assessment which will serve to act as a guide to their capacity making decisions but this was not taking place.

Accidents and incidents were now analysed each month to look for any themes or trends. This included the type of fall and the time. A reported was written which discussed any themes or trends or risks to individuals. However we found some of the figures within the report were inaccurate which may have led to the incorrect conclusion being made.

Medicine audits were undertaken but this focused solely on stock levels and not on other elements for example whether medicines were being administrated safely. In addition, the stock audit from September 2015 showed all stock levels were correct, however we found that it was often not possible to do stock checks due to lack of information recorded on MARs. In addition, the number of errors we found demonstrated this process was not sufficiently robust.

We found there was a pleasant and happy atmosphere within the home with staff and people getting on well. Staff told us they were happy in their role and said they were well supported by the manager.

People told us the manager would deal with any problems they had for example one person told us "I don't know her personally though. I would ask to speak to her if I thought it was necessary and I believe she would respond." Another person told us"[Manager[is alright. They have a good team here. They have to work together or everything would fall apart." A third person told us “She listens to you and she listens to the staff."

Some mechanisms were in place to seek feedback and involve people in the running of the service. This included care reviews and annual satisfaction surveys. The feedback from the most recent satisfaction survey was very positive indicating a high level of satisfaction with the service. No recent residents meeting had been held which was a missed opportunity to obtain people’s views in a group setting. Although people told us they were generally satisfied with the service we received some negative comments about the food, and some people said the activities on offer could have been improved. This could have been captured and addressed by the home by discussions at a residents meeting.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (g) Appropriate and proper systems were not in place for the safe management of medicines. Recorded stock balances were absent or did not tally with the number of medicines actually in stock.