C T C H Limited

Chargrove Lawn

Inspection report

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Ratings

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

Overall summary

This inspection took place on 20 and 22 October 2015 and was unannounced. Chargrove Lawn provides accommodation for up to 26 people. At the time of our inspection there were 21 people living there. Four people had recently moved into the home from another home owned by the provider which had closed and some staff had moved with them.

There were eight people living with dementia in the home. People had bedrooms with en suite facilities, some included shower rooms or baths. They also had access to shared bathrooms as well as living and dining areas. The grounds around the home were accessible to everyone.

Chargrove Lawn had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff training had fallen behind schedule and according to the provider's training records, key areas such as fire, medicines,

Summary of findings

moving and handling and first aid needed to be updated. Schedules for annual appraisals and individual support meetings had also not been maintained. There were plans in place to address these issues.

People received care which reflected their personal preferences and lifestyles, past and present. Staff had a good understanding of people's needs and how they wished to be supported. People and those important to them were involved in discussing their care needs and relatives said they were kept up to date with changes in people's needs. People's health and well-being was closely monitored and when needed referrals were made to social and health care professionals for their advice and input. If people needed additional equipment to keep them safe this was provided. People were encouraged to maintain a healthy diet. They had a choice of meals and alternatives could be provided if needed. Snacks and drinks were available throughout the day. If people had particular dietary requirements these were catered for.

People's relatives or friends were welcome to visit them and private facilities were available if needed. People had the opportunity to take part in a range of activities both inside the home and outside. External entertainers were engaged to deliver music, Jazz and folk singing and day trips included a boat trip. For people who did not wish to take part in group activities, more individualised activities were arranged such as shopping.

People and staff were confident any concerns would be listened to and the appropriate action taken by management in response. Staff had a good understanding of safeguarding and when to raise concerns. People were kept as safe as possible through the systems and processes which were in place. A thorough recruitment process made sure all the checks needed before staff started work were completed. Staff had requested training in dementia and understanding people's behaviour, which had been provided. Staff said this had really helped them to reflect about how people were feeling and how best to support them.

People's experience of Chargrove Lawn was monitored through quality assurance audits, their feedback, accidents and incidents and complaints. Improvements were evident in response to these systems. A relative commented, "Mum has been here for a long time and year on year I have seen the home get better". This was verified by a health care professional who said the improvement in the home "was quite marked".

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?

Good

The service was safe. People were protected against the risks of harm and abuse. Systems were in place to assess risks to people. Accidents and incidents were monitored and action had been taken to minimise hazards.

People were supported by enough staff to meet their needs who had been through a robust recruitment process prior to starting work.

People's medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective. People were supported by staff who had not received individual support consistently and whose training had lapsed.

People's consent to provide their care and support was sought in line with the Mental Capacity Act 2005. The relevant authorisations were obtained for people deprived of their liberty.

People enjoyed a nutritional diet, snacks and hot and cold drinks. Their individual dietary requirements were catered for. Their health and well-being was monitored closely and action was taken when people were unwell.

Is the service caring?

Good

The service was caring. People were treated with care and compassion. Staff had a good understanding of people's life histories and lifestyles, past and present.

People and those important to them were involved in making decisions about their care and support.

People's privacy, dignity and individual needs were respected and promoted.

Is the service responsive?

Good

The service was responsive. People received care and support which reflected their individual needs and wishes. They and those important to them were involved in the review of their care. Changes in people's needs were followed up to make sure they received the appropriate care and support.

People had access to a range of activities both inside and outside of the home. These reflected people's interests and took into account their personal preferences.

People were confident concerns or complaints would be listened to and action would be taken in response.

Summary of findings

Is the service well-led?

Good

The service was well-led. People, their relatives, staff and professionals provided feedback about the service through residents' meetings and surveys. Their views were used to enhance people's experience of care.

Analysis of complaints, accidents and incidents were used to improve standards of care.

Feedback about the management of the service indicated improvements had been made to the quality of service people received.

Chargrove Lawn

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.

The inspection took place on 20 and 22 October 2015 and was unannounced. One inspector and an expert by experience carried out this inspection. 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 expert's area of expertise was the care of older people and people living with dementia. Before the inspection, the provider completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also reviewed information we have about the service including past inspection reports and notifications. Services tell us about important events relating to the service they provide using a notification. Information had been shared with us by the local authority quality assurance team.

As part of this inspection we talked with 13 people living in the home and three visitors. We spoke with the registered manager, two representatives of the provider, seven care staff, two domestic staff and the chef. We reviewed the care records for three people including their medicines records. We also looked at the recruitment records for two staff, quality assurance systems and health and safety records. We observed the care and support being provided to people. We also spoke with two health care professionals during the inspection and after the inspection we contacted four other health and social care professionals.

Good

Is the service safe?

Our findings

People felt safe living at the home. They told us, "I have my own room and feel safe and sound and there are always people to look in and see that you are alright", "Wonderful place! Not like living on your own, much safer here" and "I feel that it is secure here. People know who is coming and going and you don't have to worry". Relatives confirmed this telling us, "I am away over winter and I am confident that everything will be ok" and "Yes, very safe and secure. I know that [name] is being well looked after".

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were confident these would be acted upon and the appropriate action taken by management to keep people safe. Staff had completed safeguarding training which they were about to refresh and had access to information about the local safeguarding procedures. They discussed responses to safeguarding issues at staff meetings to reflect about how they had dealt with situations. The registered manager said new safeguarding procedures put in place by the local authority were working effectively and she had discussed safeguarding concerns with them. She had notified the Care Quality Commission when safeguarding alerts had been raised and provided evidence of the action taken to keep people safe. When needed the relevant disciplinary procedures were put in place and the necessary action taken to address poor performance. Staff said they would raise concerns with the registered manager and were confident they would be listened to and addressed. Information about the whistleblowing procedure was clearly displayed in the office.

Occasionally some people became upset or anxious. Staff had raised concerns on people's behalf when they were unsure of how to support people and additional training had been provided as a result. Staff reflected how this had helped them to understand people especially those people living with dementia. Staff understood how to support people, to look for triggers which might cause them to become unsettled such as noise or the time of day. Staff described strategies they used to help people to become calmer and also to protect other people around them who might become upset by their behaviour. They were observed supporting people who became upset, reassuring them and preventing any escalation which might need further intervention. For example at lunchtime a person was becoming very confused and worried about their meal. Staff spoke calmly to them and brought sandwiches as soon as they asked for them. Staff monitored the person, escorting them to a quiet area which was what they wanted.

People were protected against known hazards such as falls, slips and trips and developing pressure ulcers. Their care plans and risk assessments provided clear guidance for staff about the risks to them and how these were minimised either by the use of equipment or by ensuring the appropriate levels of staff support. For example, equipment which had been put in place included, sensor alarms, mobility aids and special mattresses to alleviate pressure on people's skin. The least restrictive solutions were used to ensure people's safety, for instance a high/low bed with a protective mattress on the floor was provided rather than bed-sides. Wherever possible people's independence was promoted, discussing with them the risks to their mobility and providing sufficient staff to support people to walk around the home. Appropriate moving and positioning techniques were observed being used by staff. Staff said they did not leave people unsupervised in communal areas; there was always someone around to help if needed.

People who had accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. Robust accident and incident forms had been kept which were analysed to assess whether people were at further risk of harm. If needed, referrals were made to their GP or the mental health team for an assessment of their physical or mental well-being. Physiotherapist and speech and language advice had also been sought to minimise risks to people from falls or choking. Where people had a series of falls there was evidence that by taking the appropriate action these had been significantly reduced. One person who was still at risk of falling had been assessed by their GP and the occupational therapist. Sensor alarms, to alert staff when people had moved, had been provided. The registered manager had suggested moving to a ground floor room when one became available to further reduce risks. People's changing needs were closely monitored and their care records updated to reflect any changes to their care or support.

People were safeguarded against the risk of harm during emergencies such as fire. Each person had an individual

Good

Is the service safe?

personal evacuation plan which described how they should be helped to leave the home in an emergency. Fire systems were monitored at appropriate intervals and were serviced and checked when needed. An out of hours support system was in place should staff need help in an emergency. An emergency folder provided staff with information they might need to know in the case of emergencies such as utility failures, flood or staffing shortages. Day to day maintenance was dealt with as it arose and a long term environmental plan identified future improvements planned for the décor of the home. Health and safety checks were carried out at appropriate intervals to make sure a safe environment was maintained.

People were supported by sufficient numbers of staff who had been through robust recruitment checks. Before staff started working with people they had provided a full employment history and the reason they had left former employment with children or adults had been verified. A satisfactory Disclosure and Barring Service check (DBS) had been received. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for.

People told us there were enough staff to meet their needs; “I don’t have to wait too long when I need help. People are usually about” and “I have the call bell at night but don’t need to use it but it is there.” The registered manager said changes had been made to the staff rota to make sure there were enough staff on duty to meet people’s needs. For example, the member of staff sleeping in each night would now be on waking night duty for two hours at the beginning and two hours at the end of their sleep in shift, with the waking night member of staff to help them support people.

People’s medicines were administered safely. People or those representing them had given their consent for their medicines to be managed by staff. Staff had completed training in the administration of medicines, which was due to be redone for most staff. The administration of medicines was observed and found to be satisfactory. People were given their medicines at times to suit them. They were given an explanation of what they were being given and time to take their medicines. The medicines administration record (MAR) was then signed to confirm medicines had been taken. Stock levels for all medicines were kept on the MAR. Satisfactory systems were in place to return refused or unused medicines to the pharmacy. Occasionally people needed medicines to be taken as needed. Protocols were in place describing the maximum dose and the reasons for using these medicines. Records indicated these were not being overused. Some people liked to use over the counter remedies and their GP had agreed the use of these.

Requires Improvement

Is the service effective?

Our findings

People were not being supported by staff who had the opportunity to maintain their skills and knowledge. Training considered as mandatory by the provider such as first aid, moving and handling and fire, as well as medicines refreshers, had been highlighted for most of the staff for updating during 2015. This had not yet been scheduled although refresher training in the safeguarding of adults had been arranged. Planned observations of staff carrying out their work, for example administering medicines had not been completed. This meant the competency of staff to carry out their duties had not been assessed indicating whether refresher training was needed. The registered manager said allowance had been made in new rotas for staff to complete training as part of their working day, to make sure this was being done. During the inspection the registered manager confirmed training had been booked for staff which had been highlighted on the rota.

Individual support sessions (supervision) for staff were not taking place with regularity or following a consistent pattern of scheduling. The registered manager said they aimed to have individual meetings with staff every two months. An audit of supervisions completed in August 2015 highlighted staff who needed an individual meeting. Out of eighteen only one had not been held in October 2015. A few staff had received up to six meetings between January and October 2015 although one member of staff had not received any support. Annual appraisals to discuss staff performance over the year and their career development had been scheduled between September and December but had not yet been started.

People were not being supported by staff who received the appropriate levels of support and who were able to maintain their training to enable them to carry out their duties. This could potentially put people at risk of receiving inappropriate care and support. **This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People told us, "Never had any problems everybody seems to know what to do" and "I am not worried about the staff they know me and what I need". A relative said, "[Name] is well cared for by people who know what they are doing." Staff were positive about training they had recently completed about how to support people when anxious or emotional and sun downing training in relation to the effects of dusk on people living with dementia. Staff were being supported to develop professionally. Staff had been given the responsibility of leading in areas such as continence, dementia and activities. One member of staff described how they had taken the lead for a key area of people's care and had attended the relevant training. Other staff had been registered for the diploma in health and social care. Senior managers attended a local learning exchange network to keep up to date with best practice and guidance specific to their area of adult social care.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. A person told us, "Staff are very good they always ask me what I need. If I say no they listen". The provider had evidence where people had legal powers of attorney. Where a lasting power of attorney was appointed they had the legal authority to make decisions on behalf of a person, unable to make decisions for themselves, in their best interests. There was evidence that for those people unable to make decisions about their care, decisions were made in their best interests. Their mental capacity had been assessed in line with the Mental Capacity Act (MCA) 2005 and those involved in these decisions were identified, for example their GP, Psychologist or a person important to them. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Where people had been deprived of their liberty, applications had been submitted to the local authority for a deprivation of liberty (DoLS) authorisation. A DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager was aware of changes (March 2014) in the case law around DoLS and that additional DoLS authorisations may need to be submitted as a result. During the inspection a DoLS application was submitted after discussions with the registered manager about restrictions which were in place for one person.

People or their loved ones had been involved in discussions with their GP about do not attempt cardiopulmonary resuscitation orders (DNACPR). These were in place for some people and had been authorised by

Requires Improvement

Is the service effective?

their GP, with the rationale for this decision indicated. DNACPR orders are a decision made in advance should a person suffer a cardiac or respiratory arrest about whether they wish to be resuscitated.

People were provided with a nutritional diet. People commented, "Very content with the food. Look forward to it. Always plenty and nice tasting" and "Dinner, highlight of my day" and "If I don't like what is on offer they will get me something else". Where people were at risk of weight loss or dehydration this was clearly identified in their care plans and risk assessments. People's weights were closely monitored and for two people at risk of weight loss there was evidence this had stabilised. The chef had a good understanding of people's dietary needs and whether they needed a soft or mashed diet or their food needed to be fortified to prevent further weight loss. Support was provided for people at risk of choking and for other people; staff prompted them to eat or fed them. Specialist crockery and utensils were provided to encourage people to eat as well as maintaining their independence.

The meal provision had recently changed to a menu provided by an external contractor. People and their relatives had been involved in this process sampling menus before a decision was made. The menu was displayed in written form in the dining room. If people changed their minds about what they wanted to eat an alternative was offered. One person liked to have finger food and another person enjoyed a hearty cooked breakfast and mid afternoon snack, instead of eating at lunchtime. Safe snacks (which melt in the mouth) and fresh fruit were provided for people to help themselves. Cold and hot drinks were provided by staff who monitored people's fluid intake if they were deemed to be at risk. A person commented, "There is not enough drink around. I know that I can ask for one but I think that there should always be a drink around. I like water." The registered manager acknowledged they had to stop leaving drinks with people at their tables because people kept changing seats. Staff were prompted to keep people hydrated and were observed offering refills of drinks during mealtimes.

People benefited from the enhanced services provided by a local surgery, whereby one GP was responsible for visiting each week; this meant that people saw a doctor when they needed to and their medication was reviewed regularly. People's health and well-being were monitored closely and the appropriate health care professionals were contacted in a timely fashion. Records were kept of all appointments and any advice or action taken in response. Health care professionals spoke positively about the home and reported close working relationships to help people stay well.

Good

Is the service caring?

Our findings

People told us, “Staff are very chatty even when they are busy they take time to talk to me”, “Lovely carers and I mostly have people I know and who know me” and “They look after me very well. Good care, gentle care”. Staff were observed treating people with kindness and responded to them with a friendly approach. Staff understood people well chatting with them about their families and catching up on news. People’s care records included a summary of their life history and their lifestyle choices past and present. Staff knew how people liked to be spoken to, they did not talk down to people; many examples of appropriate conversations were heard. Staff also knelt or sat beside people when talking with them. One member of staff said they had not considered how frightening it could be to people living with dementia when they towered over them. Recent training had given them the opportunity to reflect on how they communicated with people and how their behaviour impacted on them. Staff also commented they enjoyed having “personal time” with people and had “more time to spend with people”.

People’s spiritual and religious beliefs were recognised and they were supported to attend religious services both within the home and at local places of worship. Some people had expressed a preference for the gender of care staff helping them with their personal care and this was respected. One person liked to have company when having a smoke in the garden and staff said they made sure they stopped by to chat with them.

When people became unwell or upset staff responded quickly reassuring people and making sure they were calm, before escalating any concerns they may have with management so the necessary action could be taken. A member of staff described how they supported one person; “[Name] can become agitated and worried at times. We all know that [name] loves aeroplanes so we start talking about planes and [name] is then fine.” Staff were observed monitoring a person who was unusually sleepy. They reported this to a visiting health care professional who checked them before staff contacted the person’s GP. They passed this information over to other staff at handover to make sure everyone was aware of the changes in the person’s well-being. People had information about local advocacy services and one person had been supported by an independent mental capacity advocate when they moved into the home.

People were involved in the planning of their care and support. They met with a named member of staff who was responsible for monitoring the service they received. People who could, signed to say they had discussed their care with staff. A person told us, “They show me my care planning from time to time and ask if there anything else I would like.” Some information was provided in easy to read formats and some posters had been displayed using a larger font. Staff had lots of ideas how to make improvements to produce information which was more accessible to people. Discreet signs around the home had been colour coded to help people living with dementia or sensory disabilities to find toilets and other rooms such as the dining room or lounge. People had chosen pictures to put outside their rooms to help them to find their bedrooms.

People were treated with respect and their dignity was promoted. A health care professional commented, “People are well treated with care and compassion.” One person said, “Staff are lovely, they don’t shout in my ear!” When people passed on their life was celebrated and remembered by others living in the home. One person had said they would like people to have a drink on them and other people had made decisions about their end of life care.

People were supported to be as independent as possible. A person told us, “I’m very independent and people know that. I choose to be in my own room and people respect my decision.” At a handover staff discussed how they could help people to remain mobile whilst managing the risks to them. People’s care records clearly stated what they could do for themselves and what they needed help with. One person with a sensory disability had been provided with a talking clock so they could keep track of the time and date. They also had a table mat which indicated where items such as drinks should always be placed so they knew where they were.

People’s right to a private life was respected. People were able to meet with friends or family in private if they wished. Visitors were made to feel welcome. They told us, “Very welcoming to me. I call this my second home” and “The staff are all very friendly and you always get a welcome.

Good

Is the service caring?

That's reassuring". There were some restrictions on visiting at meal-times. The provider information return stated, "Chargrove operates a protected meal service, however we do offer private dinner services for family or loved ones at the home if they wish."

Good

Is the service responsive?

Our findings

People received care and support which reflected their lifestyle choices, preferences and routines important to them. A person told us, "They talk to me about the care that I need. I look after myself mostly but they ask me if I would like this or that. They know me well enough and I am very content with my care." People and their families were involved in the planning and review of their care. Relatives said they had had been to formal assessment reviews. Relatives, with legal power of attorney, said care plans were discussed with them. Other visitors said they visit so regularly that they are aware of their relatives' care planning. One relative commented, "They let me know straight away if anything happens" and another said, "Any changes then they tell me". The provider information return stated, "People, their families and friends have the emotional support they need". This was confirmed by the registered manager who said they maintained close links with family and friends making sure they were kept informed of any changes in their loved one's well-being.

People who moved into Chargrove Lawn from another service owned by the provider had visited the home to decide whether they wished to move there. People had a choice between several homes and had been able to move with staff from their previous home providing continuity of care. The transition for everyone had worked well and people were enjoying their new surroundings. The registered manager had managed both homes and knew people personally. Each person had been reassessed and their care records reflected the care and support they were receiving from Chargrove Lawn. Another person had stayed for a period of respite care before deciding to move into the home permanently. Their needs had been assessed and their care records provided clear guidance about their care and support.

People needing help to manage their continence, eating or drinking, skin integrity and mobility all had care plans and risk assessments which were closely monitored and kept up to date. For people at risk of losing weight or dehydration monitoring charts were kept to evidence their diet as well as their weight. The appropriate health care professionals were involved when needed. Their care records cross referenced with tissue viability care records where risk assessments highlighted risks to their skin breaking down. Equipment had been provided when needed such as pressure relieving mattresses and cushions. Staff used strategies to maintain people's skin such as applying creams or repositioning them in bed or in their chairs.

People said they could take part in activities if they wished. A schedule was displayed which provided information about group activities such as films, bingo, craft activities, indoor skittles, quiz and board games. Entertainment, including folk singing, music and Jazz singing were provided by outside agencies. More individualised activities were provided for people who preferred not to take part in group sessions. Activities were also provided which promoted the needs of people living with dementia such as a memory ball reminiscence session. One person told us, "We all take turns on trips out. If we want to go or not never any problem with it." Other people mentioned, "Lovely it's good that there are things to do. These look good and I enjoy making things like this. (Decorating biscuits for Halloween)" and "We go shopping and the other day we all went on a boat trip. It was lovely". People also said they enjoyed going into the garden when the weather was good. One person commented, "We go out a lot when the weather is good. It is beautiful looking out on the garden."

People knew how to make a complaint and were confident any concerns would be listened to. Two complaints had been received by the Care Quality Commission and forwarded to the provider to look into. They had responded within timescales and had carried out an investigation into the issues. Two further complaints had been received by the registered manager. Where action needed to be taken this was done. For example, staff were prompted to remember to make sure people had their glasses or were warm enough. The provider information return stated when they had concerns and complaints they would "ensure any action taken is effective and changes made". People commented, "I've no complaints whatsoever. If I did have then I know that they would be sorted. It's that kind of place", "Nothing major but little things get sorted if I tell the girls" and "Would not hesitate to complain if things were not right but not needed to". Nine compliments had been received including,"Very kind staff, making him feel comfortable at all times" and thanking staff for their "Care, love and kindness".

Good

Is the service well-led?

Our findings

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Annual surveys had just been sent out. Last year's surveys had been analysed and improvements made to the service included empowering staff within their roles and improving the range of activities provided for people. Residents' meetings and individual meetings with staff also gave people the opportunity to talk about their experiences on a day to day basis. People told us, "The staff are very caring here because they like their job and they are nice people" and "Wonderful care. They really look after me well here". A relative commented, "Mum has been here for a long time and year on year I have seen the home get better". This was confirmed by a visiting health care professional who said the improvement in the home "was quite marked".

People had been supported to maintain links with the local community through attending services at local places of worship or representatives visiting them in the home. Schools had developed volunteering opportunities in the home to befriend people whilst students gained a national qualification. Another local organisation had organised visits from their clients who wished to give something back to the community. As part of this a dog had been brought along much to the delight of people living in the home. The registered manager said they were also developing links with older people living in the local area offering their hair dressing facilities and a luncheon club. They were able to provide transport to facilitate this.

People and staff had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. Staff meetings provided an opportunity for the staff team to reflect on what went well and what needed to be improved. The registered manager recognised the need to support staff to develop their skills and during the inspection had started a question and answer session around care planning to assess their training and developmental needs.

The registered manager was supported by two deputy managers. She was aware of her responsibilities in respect of submitting notifications to the Care Quality Commission. Statutory notifications are information the provider is legally required to send us about significant events. The provider's website stated their values for the organisation were that, "All staff believe that every person is an individual and as such is unique. All staff acknowledge that residents have the right to expect a high standard of care, delivered by safe, competent team members." The registered manager confirmed this stating, her vision for the home was "empowering residents, offering meaningful activities, reflecting people's individuality and forging links with the local community. They said the challenges for them were to make sure Chargrove Lawn remained a home and not a workplace and ensuring everyone's needs were being met. The representative of the provider acknowledged the low numbers of people living in the home had meant less expendable income but this had not prevented the drive for improvement. Staff had coped really well when more people had moved into the home. They had been working at other homes owned by the provider and they had developed in "confidence and insight into the organisation making them more effective workers."

People knew who the registered manager was and told us, "[Name] has a really friendly way with her and she loves her job" and "[Name] is always around. We are made to feel very welcome."

A health care professional told us, "The manager of the home is excellent." The registered manager maintained her knowledge and understanding of best practice and changes in legislation through provider meetings, membership of a local care provider's organisation, dementia link meetings and a learning exchange network. She said she felt supported by the provider through their visits to the home and their monthly audits monitoring the service provided.

People's experience of care was monitored through their complaints and accidents and incidents. Analysis of these led to improvements in the service provided such as readjusting staff levels to meet people's changing needs and providing specialist training for staff in dementia. In addition staff completed health and safety checks to monitor fire systems, water temperatures, food hygiene and infection control procedures. These were audited by the registered manager and provider to ensure safe working practices were in place. Any actions arising from these checks or audits completed by the provider were followed up to make sure the appropriate response had been taken.

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 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured that persons employed received the appropriate training, supervision and appraisal to enable them to carry out their duties. Regulation 18 (2) (a)**