Colleycare Limited

St Andrews Care Home

Inspection report

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Date of inspection visit:
03 October 2018
17 October 2018
19 October 2018

Date of publication:
08 January 2019

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**

Summary of findings

Overall summary

St Andrews is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Andrews Care Home provides care and support to up to 70 people some of who live with dementia. At the time of our inspection there were 58 people being supported by the service.

At our last inspection on 24 February 2016 we rated the service good. At this unannounced inspection on 03, 11, 17 and 19 October 2018 we found evidence from our inspection that demonstrated risks to people's safety and wellbeing. This was in relation to keeping people safe from harm, managing people's medicines safely and monitoring the quality of care provided. The overall rating of the service has changed since our last inspection to 'Requires Improvement.'

The service had a registered manager in post. 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 felt safe at the service. Staff had received relevant training on how to safeguard people but not all staff understood their responsibilities to report concerns. Medicines were stored appropriately but people on one unit did not receive these as the prescriber intended. Lessons from previous incidents were not consistently reviewed to improve the quality of care.

Risks to people's safety and well-being were identified and managed to keep them safe from harm. Assessments were in place that gave guidance to staff on how individual risks to people could be reduced. Relevant pre-employment checks had been completed for all staff and safe recruitment practices followed. People were supported by sufficient numbers of staff. People lived in a clean and well-maintained environment.

Staff had attended relevant training to their role and spoke positively about the training they were provided, however training had not always been effectively delivered. Staff felt supported, although not all staff had regular supervisions and appraisals.

People's consent was obtained, and staff were aware of how to support those people who may not be able to provide their consent. However, these decisions were not all documented as required. This was an area under review by the registered manager. People's nutritional needs were met and the deputy manager was reviewing how people were provided with additional nutritional snacks.

People told us that staff were friendly and respected and promoted their privacy and dignity. Staff knew

people well and were knowledgeable about people's individual needs. People felt staff knew what was important to them and how people chose to spend their day.

People's individual needs were assessed and people or where appropriate, their relatives were involved in the planning of how their support would be delivered. Care and support plans were regularly reviewed to ensure that they met people's current needs. However, people's care records were not always updated to reflect their preferences or choices.

People were encouraged to provide feedback on the service they received and knew how to make a complaint. Quality assurance systems were in place, but not always effectively managed such as audits of medicines and peoples records. Audits carried out by the registered manager and provider did not identify some of the areas for improvement found at this inspection. People's views and opinions were sought about the running of the home and care provided. Staff were encouraged to attend and take part in team meetings which were held regularly. Notifications of significant events were made when the registered manager was made aware of the incident by staff.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not receive their medicines as the prescriber intended.

Staff were not all aware of when to report incidents to keep people safe from harm.

Lessons learned from when things went wrong were not effectively embedded.

People were cared for by sufficient numbers of staff.

Risks to people's health and well-being were assessed and regularly reviewed.

People lived in a clean, hygienic environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training to support them carry out their job effectively. Staff felt supported, although formal supervisions had not been held regularly.

Staff sought people's consent, however this was not always clearly documented. This was under review at the time of inspection.

People's nutritional needs and specific dietary requirements were met.

People were supported by a range of external health professionals when required.

People lived in a suitably adapted and decorated home, that was well maintained.

Is the service caring?

Good

The service was caring.

Staff treated people in a kind and caring manner.

People's dignity and privacy was maintained.

People felt their views and opinions were valued and they mattered.

People's confidential information was stored securely.

Is the service responsive?

Good

The service was responsive.

People were involved in developing their care and support plans.

People received care that was reflective of their choices and responsive to their needs.

People were able to participate in a range of activities, although some people felt at times there were not sufficient staff to support them individually.

People felt confident in raising a concern or complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to monitor and improve the quality of care were not effectively managed.

Audits carried out by the registered manager and provider did not identify some of the areas for improvement found at this inspection.

Records relating to people's care were not always accurately updated to reflect people's preferences.

People and staff told us the management team were visible and supportive.

Notifications of significant events were made when the registered manager was aware of the incident.

St Andrews Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 03, 17 and 19 October 2018 and was unannounced.

The inspection was undertaken by two inspectors and one expert by experience on 03 October 2018. An expert by experience is a person who has personal experience of using or caring for someone using this type of service. The expert used for this inspection had experience of a family member using this type of service. We returned to the service on 11 October 2018 to ensure actions had been taken in relation to concerns identified at our first visit. We were subsequent to the inspection provided with further feedback on 17 and 19 October 2018 from people who wanted to share their views of the service with us.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us about the service such as information from the local authority, and notifications submitted to us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with eight people, four people's relatives, seven staff members, the deputy manager, and the registered manager. We also 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 reviewed the care records and risk assessments of five people who used the service, to ensure these were reflective of people's current needs. We also reviewed additional information relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service. One person said, "I do feel safe because there is always people around me, to check how I am." One person's relative said, "[Person] is relatively new here but so far I think they are safely cared for, I haven't had any concerns."

People were not always protected from the risk of harm by staff who knew how to identify abuse or when to report any concerns they may have. Senior staff were not clear on reporting unexplained bruising, skin tears or a pressure wound in one example. The registered manager told us about one person with a pressure wound they acquired in hospital. We asked if this had been reported to the local authority and CQC. They told us it had not. When staff were asked why they had not reported, they were under the impression it was an existing wound. Staff did not consider this to be a safeguarding concern so did not raise it. However, it was clear and confirmed with management that the newly acquired wound required reporting.

We identified similar examples for people with bruising and injuries that could not be explained that we discussed with the registered manager and senior staff.

Lessons learned where staff reviewed their practise following a significant incident were not effectively embedded within the service. We found one incident where a health professional had not changed a person's dressing regularly. Staff had reviewed their practise and responded by dating all dressings to monitor them closer. However, this was not practise consistently implemented in the home.

Prior to this inspection ongoing medicines errors had been reported to the local authority safeguarding team. These were in relation to the management and unsafe administration of people's medicines. We found further concerns regarding medicines management at this inspection, which we have reported on elsewhere in this report. This demonstrated that lessons learned did not consistently improve the safety of care.

The provider told us they had employed a compliance manager recently. Their role was to support the home with reporting concerns and improving practise through lessons learned. However, at the time of the inspection this was not in place.

This was a breach of regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

People's medicines were not administered as the prescriber intended consistently across the home. We checked the medicines management on three units. On two of these units we found medication administration records [MAR's] were complete and physical stocks matched the stock records. This meant people had received their medicine as prescribed. However, on the Windsor unit we found three people did not have their medicine on a specifically prescribed day. Over two days we found eight gaps in the recording of people's medicine administration on their MARs. Of these, four people had not received their medicine. However, the gap in the MAR did not prompt staff to raise as an incident to investigate whether the person

had received their medicine as prescribed. The lack of effective communication and reporting had been raised as a concern during previous safeguarding meetings. This meant that on one unit, people's medicines were not managed safely.

This was a breach of regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Risks to people's health and well-being were identified and managed. We saw that staff completed a range of assessments to lessen the risks to people in areas such as poor mobility, skin integrity, and risk of falls. These assessments had all been reviewed regularly. People at risk of falls had appropriate equipment was in place such as sensor mats to alert staff when they stood. Those people at risk of developing pressure wounds had an appropriate care plan in place and equipment such as pressure relieving mattresses and cushions were routinely used.

One person had a number of falls recently. The family were informed and the GP reviewed the medication, and carried out a range of tests to rule out an infection. However, the falls champion, who was a staff member specifically trained to review people's risk of falls, was able to assess the person with a physiotherapist and obtain socks with grips on the sole. This resulted in a significant reduction of falls for this person and lowered the risk of them injuring themselves.

Not all equipment bought into the home had been risk assessed to ensure suitability and safety. This placed the person at risk of injury as the equipment had not been appropriately assessed. Action was taken following the inspection to ensure the equipment was appropriately reviewed to ensure suitability.

People and staff told us there were sufficient numbers of staff available. One person said, "Absolutely there are enough staff, not just the carers, but the cleaners, cooks, maintenance are all plentiful." A second person said, "Anytime day or night if I need them [Staff] then they come straight away." The registered manager regularly reviewed and monitored the staffing levels in the home. They could demonstrate where they had increased staff when required to meet people's changing needs. However, staff told us they had time to provide safe care. But did not always have sufficient time to spend with people to support them with their own interests or activities. We have reported on this elsewhere in this report.

We looked at the recruitment files for three staff members who had recently started work at the service. We saw that relevant pre-employment checks had been completed for these staff. These checks included criminal records checks, written references and evidence of their identity. This ensured that staff employed were of sufficient good character to work with people using the service.

People told us that staff assisted them with their personal care using appropriate personal protective equipment. We observed throughout that staff used disposable aprons and gloves when assisting people. The home was bright, clean and presentable. People told us they lived in a clean environment. One person said, "You can see for yourself that it is very clean here."

Staff spoken with were aware of how to evacuate people in the case of a fire. Records showed that regular fire drills were carried out. Equipment such as alarms and extinguishers were regularly serviced and maintained.

Requires Improvement

Is the service effective?

Our findings

People told us staff competently supported them with their care and support needs. One person told us, "I think they are well trained, they seem to know what they are doing," One person's relative said, "[Person] is not the easiest to care for, but the training and support the staff get help them to really look after [Person] well.

Staff told us they had not been through a regular supervision or appraisal process, however staff felt supported. Two senior members of staff told us they had recently had formal supervision but other staff said they had not have this. When staff had received supervision with their line manager they said they found it useful. Staff said they discussed issues such as training needs, professional development and any individual concerns. One staff member who had received their supervisions said, "I had a supervision with the team leader. We looked at how I was getting on, anything I wanted to do in terms of development. I thought it was useful, I wanted to know how I was getting on as I like feedback, so I was happy to hear how I was doing and what I need to work on."

The registered manager told us supervision meetings with staff had not been regularly held. They told us they were in the process of ensuring staff received these as part of their ongoing professional development.

Staff received the training they needed to help them do their jobs effectively. Staff told us that they had opportunities for on-going training and the provider was developing their training program further. Staff had been booked onto specialist training courses to better enable them to support people's needs. Staff were trained as champions in different key areas. The purpose was to provide additional support and guidance to staff from a staff member who had been trained to a higher standard. The registered manager told us, "I have seven champions in dementia, health, wound, nutrition, engagement, falls and recently safeguarding. The champions have really helped support the staff and improve the care. Take [staff member] who is the wound champion. They can dress lower level wounds such as a weeping bandage. We had a lady who was diabetic, so the district nurse showed [staff member] how to monitor blood sugars, and they able to show other staff competently. It means we can be more responsive to resident's needs."

One staff member said, "They have given me a lot of training updates such as health and safety, medication training, communication, equality and diversity, inclusion. Even though I had worked at another home before, the team leader still observed my practise and signed me off." However, during this inspection we found training provided to staff had not always been effective. For example, staff were not all clear on safeguarding issues, medicines management or mental capacity.
Care and support was planned and delivered in line with current legislation and good practice guidance. Assessments and care plans were comprehensive, detailed and individualised. They covered areas such as communication, eating and drinking, health, personal cleanliness and comfort, mobility, daily routines, occupation, and finances. They reflected what people wanted to achieve. Care plans were regularly reviewed and updated in consultation with people and where appropriate their families.

We observed throughout the inspection staff obtaining people's verbal consent prior to assisting them. Staff

clearly explained how they wished to assist and waited for the person to respond. Where people declined and were not ready or did not wish to be helped, then staff acknowledged this and returned later.

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.

Staff had completed MCA and DoLs training, although the registered manager agreed those staff who completed the assessments required additional training. Where staff had completed assessments of capacity we saw these contained little information and were not always for a specific decision. The registered manager and staff were in the process of reviewing the MCA's for people and training had been sought to better support staff when completing an assessment. On the second day of our inspection we were shown an example of a newly completed MCA. We saw this was decision specific and detailed more clearly the specific reasons for the assessment.

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). Where appropriate, applications had been made to the relevant authorising body to deprive people of their liberty. The registered manager had a system for monitoring when DoLS authorisations were due to expire and fresh applications were required.

People were mostly positive about the choice of food provided. One person said, "I am not keen on large plates of food in general, I prefer small snacks. But I can ask for anything from the kitchen, even late at night they will make jacket potatoes with different fillings, I can eat mostly what I want every day." However, a second person said, "Not long ago we had a [staff member] serving breakfast in our dining room, but that is not the case anymore, it's now self-service. It's not that we cannot do this, on this floor we are still very able, but maybe they could ask some kitchen staff to help us."

People were supported to eat and drink enough to maintain a balanced diet. People had a genuine choice of what they ate and drank and had access to sufficient food and drink whenever needed. There was a range of snacks provided to people throughout the day, and people helped themselves to these as they wished. However, visual prompts were not provided to people who may have short term memory problems. Giving people a visual prompt, such as showing them the choices on a plate, enables them to make an informed decision about what they wish to eat. For people living with dementia, this is considered to be best practise.

Tables were nicely laid and the environment of the dining areas was sociable, calm and relaxed. Staff were seen to assist those people who required support with eating in an unhurried manner. Where people required prompting to eat their meal, staff did so in calm, supportive manner. When people finished their meal, they were then offered second helpings. Both care and kitchen staff knew about people's dietary needs and their likes and dislikes. Care plans contained details of people's food preferences, special dietary requirements and support required to eat and drink. These included plans devised by speech and language therapists where people had swallowing difficulties that put them at risk of choking, or dieticians to help promote weight gain. Staff were careful to adhere to these. We saw where people had been referred to the dietitian due to concerns about their nutrition. The dietitian's guidance was shared with kitchen staff who also provided foods with a high calorie intake and extra snacks such as milkshakes. This was intended to promote weight gain.

People's health needs were met by a range of external health professionals who visited to support people such as district nurses, chiropodists, speech and language therapists and dieticians. This was confirmed by people and with one relative who said, "[Person] gets checked by GP every week and if something is not right they will call and tell me." Each person had a folder that outlined how to support the person appropriately in event they required hospital treatment. This recorded important information such as decisions around resuscitation, dietary needs, medicines and communication requirements.

People's individual needs were met by the adaptation, design and decoration of the home. It was designed around people's needs including adaptations to make the home and garden wheelchair accessible. People had recently been encouraged to get involved with the redecorating of the home and were in the process of choosing the décor for the communal areas. People's rooms were nicely decorated and personalised with their pictures and photographs. The dementia unit was well equipped with sensory and reminiscence items such as pictures, clothes, dolls, prams and items for people to interact with. One person when holding one of the dolls was seen to visually calm when they had become agitated.

Good

Is the service caring?

Our findings

People told us that staff were kind and respectful to them. One person said, "All staff are very kind, even the cleaner always smiles back." Another person said, "It's a very good team. Especially all [staff] on this floor. I am treated absolutely beautifully. I feel very content and am not frightened to ask. I know if I ask I will get what I need."

People looked happy and comfortable in the presence of staff. All the interactions we observed were positive. People readily approached staff to talk with them or spend time with them. Staff gave people their full attention and responded to them in a friendly and caring manner.

People were supported by familiar staff who understood their needs and had developed warm and friendly relationships. Staff knew people well and were familiar with their daily needs and routines. Staff noticed when people were showing signs of being upset and swiftly provided care and support. For example, one person was distressed and upset. Staff quickly embraced the person, giving them a cuddle for reassurance and then taking them away to a quiet area. They spent time with this person, who later was seen to be content socialising in a small group and smiling.

All the staff observed showed concern for people's wellbeing in a caring and meaningful way. When we spoke with staff they gave us examples of ensuring people were offered support when upset or anxious. This included responding promptly to people's needs and offering them choices. One person said, "[Staff] are really nice people, they chat with me and we have a laugh. It's not easy to be old but I really feel that they are my friends, there is nothing they will not do for me."

People's care was regularly reviewed with the person and where appropriate with their relative. The information in the plans enabled staff to understand how to support people in their preferred way and to ensure their needs were met. However, people's views regarding spirituality or cultural needs were not mentioned in documentation, or fully understood by staff, and there were no clear written plans to address these areas.

People felt as if their views and opinions were listened to and valued by staff. One person said, "I am really content with the care I receive here. My life is different now and I needed to adapt. They listened to my worries and I know I will not be able to live on my own, but they have helped me have a sense of independence because they listen and care."

People's privacy was respected, and their dignity and independence promoted. Staff discreetly offered assistance with personal care and provided this in private. Care plans promoted independence, emphasising people's strengths and what they were able to do for themselves. One person said, "Everybody [staff] are very careful when I have to get dressed because of my bad arm. But they are extra careful and gentle, but they also encourage me to do what I can and to exercise so I can go back home quickly as possible."

People's care records were stored safely and securely and staff were aware of the importance of both people's confidence and also protecting their personal information.

Good

Is the service responsive?

Our findings

People and where appropriate their families were involved in developing their care and support plans. Their choices and preferences and how these were met were regularly reviewed. Care and support plans were individualised to reflect people's health and care needs and included clear instructions for staff on how best to support people. We found that each plan included information on people's personal background, their history and life experiences, preferences and their interests. People and their relatives said they were involved and kept up to date with changes. One person said, "I cannot think of anything I would like to change, but if I do I would be free to ask, there are no issues. My wishes are respected and listened to, not that I have to ask much, but I know if I do, then all I need is to do is ask." One relative said, "There was some changes in the medications so they called me same day. I know that if I wasn't available to attend a review, one of seniors would be able to take notes and update me later."

Staff that we spoke with demonstrated a good knowledge of what was important to people which enabled them to provide care in a way that was appropriate and personalised to the person.

Social contact and companionship was encouraged, which helped to protect people from social isolation. Staff supported people to keep in touch with their families and friends, and to maintain community links. People regularly visited community facilities, such as religious services, pubs and restaurants, shops and local parks, garden centres and regular day trips. A timetable was in place for group social activity within the home that people were positive about. One person said, "There is always something to do."

People were positive about the activity in the home. One person said, "[Activity staff] are pretty good, they change things and ask us what we want to do so things always change. We also have parties for special events like the royal wedding, that was nice." In addition to discussions, games, quizzes and movies, kitchen staff helped people make cakes, biscuits and other foods they enjoyed. People told us they found cooking extremely enjoyable as it was something they previously did, and was nice to see other people enjoying their creations.

People were also individually supported to attend events and groups that they wished to. For example one person regularly went to a sensory impairment group, and other people had regular trips to places such as the pub and garden centre which they liked to do.

However, people did tell us that at times, where care staff tried to engage with people on a one to one basis, they did not always have the time to do so. For example, one person told us they would like to go out in the garden more often, but this wasn't always possible because the number of staff available wasn't always sufficient. Carer staff confirmed this was occasionally an issue. People told us this was more of an annoyance rather than a concern, but were confident this would be improved when they raised it with the registered manager.

People were able to share their views about the care provided through regular meetings. These enabled people to discuss issues such as improvements in the home, activities for the coming month and nutrition.

For example, the chef told us about the food meetings they hold. They told us they discussed the current menu with people and sought their feedback, and would plan the menu for the following month. One person said, "The meetings are good, we all get together and get things organised."

People told us that they felt able to talk to staff if they had a concern or complaint. One person said, "I think management do listen, they often ask if everything is ok, and if we would change or like things to be done differently, we have plenty of opportunities to say and talk." A second person told us, "[Registered managers] door is always open to us and I know I can go in there and raise a complaint and they will deal with it." The service had a procedure in place to manage any concerns or complaints which was accessible to people. Records including the outcome of any concerns or complaints were recorded and monitored by the provider.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance processes were in place to drive continuous improvement. However, these were not effectively operated by both the registered manager and provider. Significant events such as accidents, incidents or safeguarding were not always identified and reported. Therefore, although the provider monitored the developing trends this was not accurate. This was because these types of incidents were not always identified and reported.

There was a programme of quality checks, including audits within the service overseen by the registered manager. Staff checked things like fridge temperatures, food temperatures, bath temperatures, finances, medicines, and care plans. There were also frequent checks of environmental health and safety and fire safety. However, our inspection identified issues with the safe management of medicines and assessing and documenting consent for people. Learning from safeguarding concerns or significant incidents had not been embedded within the staff culture. Although the registered manager could evidence where this had occurred, we found it remained an area for development.

The overarching audits carried out by the provider did not regularly identify and monitor improvements that were required in the service. Audits were carried out by a range of different managers. Each looked at their own specific area, identified an improvement required, and updated the key line of enquiry action plan. However, there was not a regular review of the improvements required, resulting in areas not being reviewed for six months or more. The registered manager told us they along with other managers had raised this as an issue. They said they had told the provider they wanted a change in the way the provider reviewed and monitored the service. The provider had agreed to employ a new staff member, who would regularly carry out a CQC style inspection. This, the registered manager told us was the favoured approach, and were looking forward to a more robust system of governance being implemented.

Staff demonstrated an in-depth awareness of people's needs, life histories and preferences. However, care records we looked at did not contain this level of detail, for example they did not record those preferences or people's spiritual or cultural needs. The registered manager was in the process of transferring care records from a paper system to an electronic system and was an ongoing piece of work. However, staff referred to the electronic care plan and not the paper records. This meant that staff may be inadvertently misinformed of people's care needs because the record had not been accurately maintained. This is an area that requires improvement to ensure care records are accurate records of a person's care.

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

People said the management team were supportive and approachable. One person said, "I think [Registered manager] is doing a very good job because we are well looked after and nothing major is missing here." One relative commented, "Management is working very hard to improve this place, every room will have en-suite shower rooms, the ones that have been done look really nice." One staff member said, "I love my job It's a good company to work for."

Staff were positive about the provider. They were aware of the changes in the organisation and new developments, both in the home and within the company. Staff were clear on the ethos of the provider, and felt in recent months the provider representative had been more visible and approachable. The registered manager told us, "[Provider] is now beginning to listen to us as managers. I feel we are becoming more up to date and with more robust systems to support us. Whatever I put in for now I need I will get, in the managers meetings I feel as a collective our views have been heard."

Staff told us team meetings were regularly held and they found them to be supportive and informative and that their views were listened to. One staff member said, "Staff meetings are good, we get feedback on stuff to improve on. The meetings can be framed so the carers can discuss issues without the seniors being present. It allows the carers to be more open about how things are." The demonstrated that the registered manager promoted an open and inclusive working environment. Staff morale was good. All staff we spoke with were proud to work at the home. When we spoke with them they responded with an enthusiasm and passion for the work they did.

People and relatives feedback was sought on the quality of care provided through surveys. The results of these were reviewed and where improvements were required these formed parts of the registered managers action plan. In addition, through regular meetings, informal discussions with people, and having an open-door policy, the registered manager was able to regularly get people's views. One person said, "[Registered manager] is always around checking things are okay. If I need to I can go to the office, they are never too busy and will make time to talk to me. I know [Relative] has spoken about things that needed work and they did it."

The registered manager understood and worked in line with regulatory requirements. They had made statutory notifications as required by the regulations. The current Good rating was displayed prominently in the downstairs hallway, as well as being reflected on the provider's website.

The service worked in partnership with other agencies to support care provision. For example, staff liaised with local voluntary agencies to support people, or transport people to appointments. People were encouraged to maintain links with the local community, to use facilities such as shops and to develop social networks.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) People were not protected from the risk of harm from unsafe care or treatment and people did not receive their medicines as prescribed.

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 Regulation 13 (1) (2) People were not protected from the risk of harm and abuse because systems in place were not effectively operated to identify and respond to evidence of harm occurring.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) Systems were not effectively used to assess, monitor and improve the quality of care people received. People's records were not consistently updated to reflect people's needs or personal preferences and choices.