

Sanctuary Care Limited

Meadows House

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 01 and 03 December 2015 and was unannounced. At our last inspection 17 September 2014 we found the provider met all the regulations we inspected.

Meadows House Residential and Nursing Home provides nursing and residential care for up to 59 older people with dementia care needs.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has

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

We found breaches in legal requirements in management of medicines, assessments of risks, person centred care and assessing and monitoring the quality and safety of

Summary of findings

the service provided. People's allergies were not consistently recorded; therefore, people were put at risk of receiving medicines that may have an adverse impact on their health and safety. Appropriate information was not always in place for the application of topical creams. Medicines to be given when required did not always have the appropriate protocols to ensure information was available to staff to provide care and treatment that was safe and met individual needs.

Some risks to people's health and safety had not always been recognised or assessed adequately and acted upon. People's care plans included relevant risk assessments which were reviewed monthly; however, where significant changes had occurred the frequencies of these assessments were not reviewed to meet people's changing needs and monthly care plan reviews did not always reflect changes in people's health conditions. People's health charts were not always updated to evidence the care being provided was meeting their needs. Each person who used the service had a care and treatment plan in place. However, there was little in the way of individual needs being recorded.

People's records including their health charts were not always completed to confirm their needs were being met.

The provider had monitoring checks in place but this was not always effective as they did not identify the concerns we found at our inspection.

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

We found some areas required improvement. The provider had an activities coordinator in post; however more could be done to aid people's physical and mental stimulation. The provider had systems in place to assess the number of staff required to support people; however, this may not be sufficient in some cases and the provider informed us they would review their staffing level in line with best practices.

People and their relatives were complimentary about the home. There were safe recruitment protocols in place. There were procedures in place to protect people from abuse. Staff had received safeguarding training and demonstrated they knew what to do if they suspected abuse had occurred. There were arrangements in place to deal with foreseeable emergencies.

All staff had undergone an induction when they started working at the home and had received appropriate training to ensure they had the skills and training required for their role. Staff were also supported through regular supervision in line with the provider's policy.

People had enough to eat and drink for their wellbeing. Where required, people had access to a range of healthcare professionals to ensure they received care and treatment that was safe and met their needs. Staff were aware of the need to ensure people consented to their care and treatment and both staff and management teams demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People and their relatives told us that staff were kind and caring towards them and we observed this during our inspection. People's privacy and dignity were respected and independence promoted where appropriate. People and their relatives were involved in making decisions regarding their care and treatment plans. People's religious needs were promoted and people were encouraged to maintain relationships. Where appropriate end of life care plans were in place for people to ensure their wishes were respected.

The provider had a complaints procedure in place and people told us they knew how to complain if they were not happy about the service. People could express their views about the service and their views were taken into consideration and acted upon.

People felt the service was well-led. Staff we spoke with told us they were happy working at the home.

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 always managed safely. Risk to people had been assessed but these were not always reviewed to meet people's changing needs and people's health charts were not always updated to evidence the care being provided was meeting their needs.

Staff were aware of their responsibility to safeguard people in their care and knew of reporting and recording procedures.

Appropriate recruitment checks had been completed before staff begun working at the home. The provider had systems in place to assess the number of staff required to meet people's needs; however, this may not be sufficient in some cases and the provider informed us they would review their staffing level in line with best practices.

Requires improvement



Is the service effective?

The service was effective. All staff had received an induction when they started work at the home and had received appropriate training and supervision to effectively perform their roles.

There was sufficient amount of food and drink available to ensure people's nutritional needs were met. Appropriate support was in place for people who could not eat independently.

Good



Is the service caring?

The service was caring. People and their relatives told us staff were kind and caring towards them. Interactions between staff and people were friendly and relaxed.

People's privacy and dignity were respected and their independence promoted where appropriate. Staff demonstrated an understanding of people's religious and cultural needs and the support they provide.

People and their relatives told us they were involved in making decisions regarding the care and treatment plans in place. Where appropriate, people had end of life care plans in place to ensure their end of life wishes were respected.

Good



Is the service responsive?

The service was not always responsive. Each person who used the service had a care and treatment plan in place. However, there was little in the way of individual needs recorded. Monthly care plan reviews did not always reflect changes in people health conditions.

The provider had an activities coordinator in post; however more could be done to aid people's physical and mental stimulations.

Requires improvement



Summary of findings

The provider had a complaint policy in place and people who used the service knew how to make a complaint if they had any concerns.

Is the service well-led?

The service was not always well-led. The provider did not always have an effective system in place to assess and monitor the quality of the service. We saw that there were monthly, quarterly, and annual audit carried out by the management team. However these audits did not identify some of the issues we found at our inspection in areas such as medicines management, risk to the health and safety of people and records management.

People could express their views through residents and relatives meetings or an online forum and their views were taken into consideration and acted upon.

People were complimentary about the management team.

Requires improvement



Meadows House

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 01 and 03 December 2015 and was unannounced. On the first day the inspection team consisted of a single inspector and a specialist advisor. On the second day two inspectors returned to the home accompanied by 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.

Before the inspection, we looked at information we held about the service including information from any notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

At the inspection, we spoke with six residence and two relatives. We used the Short Observational Framework for Inspection (SOFI) to help us understand people's experiences during the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We interviewed five care staff and two nursing staff, one housekeeper, one activities coordinator, the home manager and the area manager. We also spoke with a visiting health professional. We looked at 11 care plans and we looked at records relating to staff recruitment, training and supervision. We also looked at other records used in the management of the service such as policies and procedures, audits, meetings, staff rota, activities planner, complaints and safeguarding logs.

During our inspection, we contacted the Local Authority Commissioning and Quality Team to obtain their views about the home.

Is the service safe?

Our findings

People said they felt safe living at the home that staff were caring and their needs were being met. Despite the compliments from people and their relatives about their safety, we found that risks to people's health and safety had not always been recognised or assessed adequately and acted upon.

People's care files included risk assessments in areas such as falls, manual handling, nutrition, medication, continence, call bells and water low. For each risk assessment, there were relevant care plans with guidance for staff on how to prevent or mitigate identified risks. Staff we spoke with knew of these control measures and told us of the support they provided. The risk assessments were reviewed monthly in line with the provider's requirements. However, we saw that in two cases where significant changes had occurred in people's health conditions, the frequency of monitoring the risks had not been reviewed to meet their changing needs. For example, weight charts we looked at showed two people had lost significant amounts of weight between September 2015 and October 2015. Assessments carried out indicated they were of high risk of malnutrition and dehydration. In spite of this, the frequency at which their weight was being monitored had not increased but remained on monthly basis. Both people concerned were assessed by a dietician in September 2015. However following the dietician visits, nutritional care plans were not updated to reflect the dietician's recommendations to ensure all staff were aware of current guidance on how to care for people.

All the care plans we looked at were generated within the last year and then reviewed monthly to ensure people's changing needs were monitored and recorded. However, the monthly reviews gave little information on any changes in people's health conditions such as weight loss or gain, skin integrity or nutritional needs to ensure that information was readily available to staff in providing safe care and treatment. This showed that people were being put at risk of receiving unsafe care and treatment because changes in their health conditions were not being appropriately recorded.

People who used the service were put at risk of receiving inappropriate care and treatment because their health charts were not adequately completed and monitored. We saw that people's health charts including weight,

positioning and food and fluid charts did not always contain the right information and in some cases conflicting information. For example on 09 November 2015, there were two weight records for an individual who had lost substantial amount of weight. On the same day, one weight record read 62.90 kilos and another 80 kilos. This meant that the person was at risk of receiving inadequate care and treatment if the wrong information was used in their care provision. Food and fluid charts were not always completed adequately to demonstrate that people's required food and fluid intake was being met. For example for one person, we saw two entries of fluid intake which added up to 350mls and one entry of food intake in a 24 hour period. Also, people's food and fluid intake in some cases were being recorded on positioning charts for people who required two staff to support them mobilise. The lack of information being recorded and monitored appropriately meant staff would not know if someone was dehydrated or malnourished,

The provider had arrangements in place to deal with foreseeable emergencies. Staff were aware of emergency procedures and the actions to take including contacting the emergency services. Staff had also completed first aid and fire safety training to ensure they had appropriate skills to support people in the event of an emergency. All the care plans we looked at had personal emergency evacuations plans (PEEP) in place. However in two cases, we saw that the personal evacuation plans were not completed to ensure people were safely evacuated in the event of an emergency.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these issues to the attention of both the home and area managers on our first day of inspection. By the second day, we found that people's risk assessments including their personal emergency evacuation plans and people's health charts were being updated to ensure safe care and treatment was provided.

Medicines were not always managed safely. Medicines administration records (MAR) did not always record people's allergies consistently. We found contradictory information on some MAR charts, for example, the front pages of two people's MAR stated they had no allergies whilst subsequent pages stated they were allergic to

Is the service safe?

medicines such as penicillin. Records for two other people we looked at were inconsistent and this put people at risk of receiving medicines that may have an adverse impact on their health and safety.

Medicines were not always administered safely. The MAR charts were completed confirming that people were receiving their medicines as prescribed by healthcare professionals. However, we found two gaps on the MAR. The home manager informed us that these medicines had to be omitted on certain days of the week. However, we found no information on the MAR chart to indicate these medicines were to be omitted on certain days of the week. This showed that people were therefore put at risk of receiving an overdose or not receiving their medicines when required as there was insufficient guidance for staff.

Those medicines to be given when required (PRN) did not have all of the information and individual protocols included to guide staff on their use. On two occasions we found that certain medicines were required to be given to people when needed including some pain killers. However, there was no guidance on the MAR for staff to follow such as dose, reason, frequency, duration and any precautions staff should follow when administering PRN medicines.

Where topical creams were used, appropriate records were not always being maintained to confirm that people were receiving their medicines as required. Supporting body maps did not include information on which part of the body the cream should be applied to. Some topical creams were without names, many without dates of opening and non with expiry dates. Therefore people were at risk of receiving topical creams inappropriately due to the lack of information.

Medicines were not always recorded safely. Any changes to MAR were not always recorded effectively to prevent discrepancies. For example, we saw that the time a person's medicine was to be administered had changed, yet there was no staff signature to confirm this amendment was correct. We saw a MAR chart which had lines scoring through them without staff signatures or dates of the record to ensure information was correct and avoid discrepancies.

These issues were breaches in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These concerns were brought to the attention of the home and area managers on our first day of inspection. On our second day of inspection we found that MAR charts had been updated and appropriate protocols were in place for the safe management of medicines.

Medicines were kept safely. Medicines were stored securely in a locked trolley in the clinical room. A monitored dosage system supplied by a local pharmacist was being used to administer medicines. On the nursing unit, only trained nurses administer medicines and senior care staff administered medicines on the residential units. All staff eligible to administer medicines had received training on the safe management of medicines.

The provider had systems in place to assess the number of staff required to provide safe care and treatment. We received mixed feedback regarding the staffing levels from relatives and staff. A relative told us, "I've been quite impressed by the stability of the workforce. But there are not enough staff...all the residents needed more one-to-one interaction and that means more staff." Most staff felt there were enough staff to support people however others told us more could be done to ensure people received quality care. One staff said, "I feel people are well looked after here but we need more staff." We looked at the staffing rota against the number of staff planned for and we found this information to be consistent. Staff could also work extra hours to cover vacant shifts where required. On one of the nursing units, we found staffing levels were reduced in the afternoon although the number of people on the unit and their needs had not changed. Staff told us of the difficulty they faced in carrying out their role effectively at such times. We brought this to the attention of the home and area managers and they told us they would review their staffing levels in line with best practices. However we were unable to monitor this at the time of the inspection.

Before staff began working at the home appropriate recruitment checks were carried out to reduce the risks of employing unsuitable staff. Staff files contained application forms which included details of their qualifications, employment history and fitness to work. Two references had been obtained, proof of identification, evidence of the right to work in the United Kingdom and criminal records checks had been carried out. This showed that the provider had safe recruitment and selection processes in place to ensure people in their care remained safe.

Is the service safe?

People told us they felt safe living at the home. The provider had safeguarding and whistleblowing policies in place and staff we spoke with knew how to recognise the signs of abuse and about the relevant reporting and recording procedures. All the staff told us they would report to their manager or the person in charge if they had any concerns. Staff said if their concerns were not addressed they would report to someone higher in the organisation, the local authority or CQC. There were five on-going safeguarding concerns at the time of our inspection. The

provider had worked with the local safeguarding team to investigate any allegations of abuse. Where required, the provider took appropriate actions to protect people from unsafe care and treatment.

Weekly fire tests and quarterly fire drills were completed to ensure fire equipment were working safely and staff knew of protocols to follow in the event of a fire. Portable appliance test (PAT) records showed electrical devices had been checked and were safe for use. A legionella test had also been completed to ensure the water supply was safe for use.

Is the service effective?

Our findings

Relatives we spoke with were complimentary about the staff team. One relative said, “I think the staff team here are good and it’s nice to know Dad is being well cared for.”

Appropriate support was in place for staff. All new staff completed an induction when they began working at the home. New staff we spoke with told us that the induction included training, shadowing an experienced member of staff and familiarising themselves with the home to ensure they had the right skills for the role.

Training records showed that staff had completed training in areas which the provider considered mandatory this included Dementia in Care, Fire Safety at Work, First Aid, Food Safety, Health and Safety, Infection Control, Safeguarding Adults at Risk, Mental Capacity Act and DoLS.

Staff received regular supervisions and all staff we spoke with told us they felt well supported through supervision. Staff supervisions took place every two to three months and staff told us that any issues raised during supervision sessions were dealt with appropriately. Not all staff could recall they had received an appraisal, and we found that the appraisal process had changed. The provider told us new appraisal system was in place which was due to begin in January 2016 to ensure staff received the appropriate development they needed in their role.

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 were aware of the importance of gaining consent from people when offering them support. They were familiar with the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff told us of how they supported people by giving them opportunities to make decisions and choices for themselves when providing personal care. They told us that when people could not make specific decisions for themselves best interest meetings took place involving the person using the service, their relative where applicable, staff and other healthcare professionals involved in their

care. Where people did not have any advocates, Independent Mental Capacity Advocates were involved in making decisions in their best interest. We observed staff offering choices and respecting people’s decisions throughout our inspection. Records showed that mental capacity assessments had been carried out where this was appropriate and best interest decisions made for example about the use of bedrails.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the provider was working within the principles of the MCA and DoLS and had submitted an application to a ‘Supervisory Body’ to request the authority to legally deprive some people of their liberty when it was in their best interest. We saw that applications under DoLS had been authorised and that the provider was complying with the conditions applied under the authorisation.

People told us they had enough to eat and drink and they were given choices of food and drink. People were supported to eat and drink adequate amounts for their wellbeing. At lunch time there were two choices of meals and staff asked people for their preferred choice and in some instances they showed people the choices available. We saw a person who requested for a different meal than what was on offer and this was prepared for them. People were also offered drinks of their choice and we saw people had a range of drinking utensils such as beakers and straws to encourage their independence. Some people were offered pureed food in line with their nutritional care plan. People who required staff support to eat sufficient amounts for their wellbeing were adequately supported. Music was being played in the dining rooms whilst people ate and the atmosphere was relaxed and friendly. The kitchen staff were aware of people’s nutritional needs and the support to provide.

People and their relatives told us they had access to various healthcare professionals and we saw the professionals’ records were kept in people’s care files. Other healthcare professionals involved in people’s care included a visiting GP, dentists, speech and language therapists (SALT), Occupational Therapists, physiotherapists, dieticians, tissue viability nurses (TVN) and various hospital appointments were made to ensure

Is the service effective?

people received care and treatment that was safe and met their needs. We also found that the local commissioning group was involved in the review of people care and treatment plans to ensure appropriate care and treatment was in place for people and their needs were met.

Is the service caring?

Our findings

People told us that staff were kind to them and supported them in ways that met their needs. A relative told us, “The nursing staff are incredibly supportive and caring and I think the care workers meet the residents’ needs with great respect and dignity”. Another relative said the staff are “marvellous”.

Staff interactions with people were thoughtful and promoted positive relationships. The atmosphere in the home was relaxed with music playing in most communal areas. We observed staff calling people by their preferred names when speaking or referring to them. In each care plan there was a detailed life history which included people’s family history, previous education and occupation and things they did for leisure to ensure their care provider knew about their lifestyle they had lived. Staff we spoke with demonstrated a good knowledge of the people they cared for and understood their needs including their likes and dislikes. Staff were able to tell us about some people’s life history and relatives involved in their care.

People and their relative told us they were involved in the planning of their care and support. A relative told us that they were involved in the care plan reviews and saw the care plan all the time because “I need to know everything is being done right when I’m not here”. They told us of the improvements made in their loved one’s care and treatment. Staff we spoke with confirmed that people were involved in their care planning and decisions relating to their care and support. One staff member said, “We always involve them as much as we could in every decision made”. Care records we looked at had been signed to demonstrate people were involved and were in agreement to the care and treatment plans in place for them.

People told us their privacy and dignity was respected. Staff told us of ways they promoted privacy and dignity. For example, they knocked on people’s doors, sought

permission before entering their rooms and before supporting people with personal care. During our inspection we observed this to be the case. Staff told us they promoted people’s dignity and independence. For example they encouraged people to wash certain parts of their body if they were capable of it and assisted with other parts they could not do by themselves.

People were supported to maintain relationships. Visiting relatives we spoke with told us they could visit the home at any time and that there were no restrictions in place. Relatives told us they could take their loved ones out into the community if it was safe to do so and staff we spoke with confirmed this.

People were supported to practice their faith where required. People told us they were supported to practice their spiritual beliefs. The provider informed us of spiritual representations who visited the home to support people with their faith. Staff we spoke with told us that some people preferred certain kind of music in their rooms because of their religious beliefs and their choices were respected. Where people had no spiritual interests or needs, their views and wishes were respected.

People were supported with end of life care where required. The provider worked in collaboration with a local hospice to ensure people’s end of life wishes were respected. Some people had completed end of life care plans with the support of their relatives and staff. It was some people’s wish that their family took charge of decisions for them and other people did not want to be hospitalised in their last days. People’s capacity had been assessed in relation to their end of life care. Where people did not want to be resuscitated, we found Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms had been completed and signed by people, their relatives [where appropriate] and their GP to ensure people’s end of life care wishes would be respected.

Is the service responsive?

Our findings

People and their relatives we spoke with told us they were involved in the planning of their care and their views were taken into considerations when developing the care plans.

Each person using the service had a care and support plan in place. Each care file included pre- admission information, risk assessments, care plans, multidisciplinary visits and forms for recording communications with relatives. The care plans we looked at covered areas such as care and accommodation, communication, nutrition, personal care, sleep, manual handling, comfort, and anxiety. However, the care plans were not always personalised to reflect individual needs. For example, we found that some people required incontinence wear; however, their care plans did not include the type and size of incontinence wear nor frequency of support with this. Another care plan stated that an individual using the service could choose their own clothes yet their communication care plan stated their communication skills were limited and staff said the person could not do this for themselves. This showed that the care and treatment plans in place were not always individualised to people's needs therefore people were at risk of receiving care and treatment did not meet their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These concerns were brought to the attention of the home and area managers and they informed us they would review their care plans to ensure it contained adequate information and was individualised to each person using the service. However, we were not able to monitor this at the time of our inspection.

The provider had an activity coordinator in post who was responsible for organising activities for all the people living at the home to support their physical and mental wellbeing. A weekly activities programme included reading newspapers, quizzes, sing along, throwing of soft balls and cinema sessions. There was also a reminiscence room in the home to stimulate people's memory; however we did not see anyone using it on both days of our inspection visit. We found that the amount of activities available to people was limited as we saw people either sitting idle or restless without any effective stimulating activity to engage them.

Relatives we spoke with told us that more could be done to provide stimulating activities for people. Some comments from relatives included, "The activities co-ordinator is very good but they struggle to provide stimulation for everyone, with so many floors and different units. They do have entertainers coming in, but only on special occasions. There are so many people living here, they can't do everything." Another relative said, "The activities co-ordinator does their best and the other staff as well. They did some cake icing recently and they play soft-ball games and they do take (my family member) for little walks around the unit. They do their best for everyone but it is a big home and they can't be everywhere all at the same time". The activities coordinator told us additional support would be appreciated as there were so many residents some of whom needed one to one support. We found that although there was some level of activities being provided, this was not always adequate in meeting people's needs especially because most of the people who used the service have some level of mental health needs and/or behaviours that challenge and therefore needed appropriate stimulation to support their memory and social interactions. We brought this to the attention of the home and area managers and they told us they would work with the activities coordinator to ensure additional support was in place so that people's physical and mental wellbeing would be adequately stimulated.

We saw that the home had some features in the communal areas such as a sample post box, telephone box, and street signage to stimulate people's memories. There were also clocks and calendars available in communal areas and some people's bedrooms. However, we saw that bedrooms that had clocks and calendars were incorrect. These issues required improvement to stimulate people's memory and orientations.

People and their relatives told us they knew how to make a complaint if they were unhappy about the service. There was information on how to make a complaint displayed in the home. People told us they would speak to the person in charge or the home manager and they were confident any issues reported would be dealt with. Complaints log showed that all complaints were clearly recorded where they had been raised and information regarding investigations undertaken and any actions taken in response to the complaints had been maintained.

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality of the service but these were not consistently effective. We saw that audits were carried out in areas such as medication, care planning, infection control, staffing, accident and incidents, safeguarding, complaints, human resources and clinical data. However, the systems in place did not identify some of the concerns we found at our inspection in areas such as medicines management, risk assessments and records management. This showed that the systems in place were not effective to identify shortfalls in the care delivery.

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

We saw that the regional manager carried out their own audits to ensure any issues identified in these audits and any previous audits had been actioned. Where issues had been identified these had been logged and actioned. For example an audit carried out in November 2015 by the regional manager identified that Meadows House appear not to be performing to its full and normal standards because of vacant nursing staff and also the home manager did not have a clinical manager in post therefore had not been able to give as much time to the day to day management of the home. The provider told us they were currently recruiting into the clinical manager's posts to ensure the care provision and the management of the service improved.

At the time of our inspection, there was no registered manager in post. The home manager informed us they were in the process of fulfilling their legal responsibilities by registering with CQC. We found that the home manager was appointed to post in July 2015.

Residents and relatives meetings were held to gather the views of people to improve upon the service. We saw minutes of two meetings that had taken place in 2015 and areas of discussions included food, laundry care, staffing levels, personal care, activities and how to make a complaint. However we found that relatives meetings were no longer being held at the home and had moved online and was called a "family forum". The home manager told us the provider had no involvement in the family forum but that the home received regular feedback from relatives. A relative we spoke with expressed their interest in joining the relatives meetings. We brought this to the attention of the home manager and they informed us that they would consider reintroducing relatives' meetings at the home to ensure everyone's views were used to improve the quality of the service provided. After our inspection, the provider contacted us to inform us face-to-face relatives meetings were held at the home and we will monitor this at our next inspection.

People and their relatives knew who the home manager was and told us they felt the home was well led and people spoke positively about the management team. Staff we spoke with were complimentary of the management team. One staff member told us "I am very happy here". Another staff member told us that when they had difficulties in their role and reported this to the home manager, they took immediate action to ensure they were happy in their role.

The local authority commissioning team we contacted told us they felt the home was well run and staff were very caring. The management team were also very transparent about alerting them of any incidents and they were willing to put procedures in place to prevent adverse incidents from happening again. They told us that one of the home's units was used as an exemplar for other homes within the borough to visit to demonstrate what can be done to improve the environment for people with dementia.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were at risk of receiving inappropriate care and treatment because their care plans did not reflect their individual preferences to ensure their needs were met. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not always protected against the risk of unsafe management of medicines and the risks to people's health and safety had not always been recognised, assessed adequately and acted upon. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service provided and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17