

Four Seasons Homes No.4 Limited

The Maltings Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

The Maltings Care Home is a residential care home providing personal care to up to 43 people in a purpose built building with an upper and a lower floor, each with a separate dining room and lounges. At the time of our inspection there were 19 people using the service.

People's experience of using this service and what we found

Although there was an improvement in the oversight of many aspects of the service, some basic oversight was not in place. Food and fluid charts, repositioning charts and records monitoring people's continence were not always completed accurately and were not effectively monitored. One person's medicines had not been accurately entered onto the system following their discharge from hospital. This poor recording represented a failure of systems which have the potential to harm people and meant there was a continued breach of regulation relating to the monitoring and mitigating of risk.

However, we also noted that the service had improved in all other areas, despite not having a consistent registered manager in post. The provider had worked hard to ensure continuity of leadership even though this had been a challenge. People who used the service, relatives and staff were mostly positive about the service and had confidence in the provider.

The provider conducted effective health and safety monitoring of the environment. Staff were recruited safely and there were enough staff to meet people's needs. There were good infection control practices in place and safeguarding concerns were well managed.

Healthcare needs were mostly well documented, but some records required closer monitoring. Pre-admission assessments were in place. Staff, including agency staff, were well trained and received a good induction. Consent was well documented, and staff had an understanding of the issues relating to consent. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The environment was much improved and there were plans in place to encourage people to use communal spaces more. There was some mixed feedback about the food but overall people were happy with their meals.

Staff were kind and caring. Interactions were positive and people were treated with respect. People were involved in decisions about their care.

Care plans documented people's specific and individual needs well. Staff knew people well and information, except that in some people's room folders, was well recorded and handed over from shift to shift.

Activities were varied and people were positive about them. End of life care plans were in place and people's wishes were documented. Complaints were managed well. People had a voice and residents meetings enabled people to raise issues or concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was inadequate (published 3 October 2020).

We placed conditions on the provider's registration which required them to submit a monthly action plan to us so that we could monitor them more closely and ensure the required improvements took place.

At this inspection we found the provider had made significant progress but remained in breach of one regulation relating to leadership and governance.

This service has been in Special Measures since 2 October 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement

We have identified a breach of regulation in relation to the monitoring of people's health and inaccurate record keeping. Please see the action we have told the provider to take at the end of this report.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

The Maltings Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection was carried out by three inspectors, one of whom was a medicines inspector.

Service and service type

The Maltings Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Maltings Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there not a registered manager in post as they had left the service the previous week without notice.

Notice of inspection

This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection, including notifications of significant events which the provider is required to tell us about. We sought feedback from the local authority quality improvement team. We used the information the provider sent us in the provider

information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with the regional manager, the regional support manager (who was in day to day charge of the service), three senior care staff, the activities co-ordinator, the chef, two care staff and two domestic staff. We also spoke with six residents and three relatives. We reviewed six care plans in detail alongside sections from others and 14 medication administration records.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess and mitigate the risks relating to people's health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People's care plans contained risk assessments relating to a variety of risks including falls, choking and moving and handling. Care plans documented actions staff should take to reduce these risks.
- However, risks relating to one person's pressure care and the monitoring of some people's eating and drinking were not well recorded on the care plan folder which was kept in their bedroom. Staff were recording information in different places as they were not clear about the process.
- Incomplete records meant that, should other healthcare professionals, such as paramedics, ask for information in an emergency, this could not be provided quickly and was not accurate. This posed a potential risk. However, we judged this to be a recording issue rather than a lack of care.
- The provider immediately began to address this when we fed this back. Procedures for accurately recording information were already in place in some people's room folders and the provider ensured all the required records were in place before our inspection was complete.
- Risks posed by the environment were well managed. Equipment and systems, such as the fire system and moving and handling equipment, were maintained and serviced in line with a structured schedule and regularly tested to ensure they were safe.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff were recruited safely. This was a breach of regulation 19 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- Staff were recruited safely and there was a robust recruitment procedure in place. The provider also checked agency staff had the required training and checks in place, such as the Disclosure and Barring

Service check (DBS). DBS checks provide information, including details about convictions and cautions, held on the Police National Computer. The information helps employers make safer recruitment decisions.

- There were enough staff to meet people's needs. People who used the service told us they did not have to wait long to get the help and support they needed. The atmosphere in the service was calm and staff had time to chat with people.
- The number of people using the service had reduced since our last inspection. However, the provider had tried to maintain generous staffing levels in order to bring about the improvements required following that inspection.

Using medicines safely

At our last inspection the provider had failed to ensure the safe administration of medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Records showed overall that people received their medicines as prescribed. There were regular checks to ensure this and there were clear reporting procedures for when medicine errors were identified leading to actions for improvement. A medicines administration error was identified during our inspection and the provider took all appropriate action to investigate the incident and reviewed procedures immediately to reduce future risk.
- There was written information for staff to refer to about how people preferred to receive their medicines. For people who were prescribed medicines to be given on a when required basis (PRN) there was written guidance available for most, but not all, medicines prescribed in this way.
- We noted that some of the guidance lacked sufficient person-centred detail to enable staff to give people their medicines consistently and appropriately.
- Staff had received training on medicine management and had been assessed as competent to give people their medicines. We observed staff gave people their medicines by following safe procedures.
- Oral medicines were stored securely and at correct temperatures.
- If they wished, people were supported to maintain independence and handle some of their own medicines. However, risk assessments about this had not recently been reviewed to ensure people continued to do this safely.

Preventing and controlling infection

At our last inspection the provider had failed to ensure the risk and spread of infection was effectively controlled. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using personal protective equipment (PPE) effectively and safely.

We observed staff wearing appropriate PPE and people who used the service confirmed this was always the case.

- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- The service was clean and there were no odours. Domestic staff had a clear action plan to reduce the potential risks relating to COVID-19. Additional cleaning had been introduced during the pandemic and this had continued.

Visiting in care homes

- The provider facilitated visits from family and friends in line with current government guidance. People were supported to maintain contact with their loved ones and one person told us about a celebration birthday party they had been able to arrange earlier in the year, whilst still abiding by all the COVID-19 rules in place at that time.

Learning lessons when things go wrong

- Although the provider investigated and analysed incidents, often in great depth, some incidents still reoccurred. The provider's processes did not always facilitate learning from incidents in a practical way which ensured they reduced. However, we noted that the provider took immediate and effective action following the medicines administration error we identified.
- Staff understood the importance of reporting and recording accidents and incidents.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person said, "I feel very safe here. ...If they [the staff] think you are unwell or worried they will get one of the seniors. They notice things."
- Staff were clear about safeguarding practice and had made safeguarding referrals when this was required. Lessons had been learned and new practice implemented following safeguarding investigations.
- Staff received training in recognising the signs and symptoms which might suggest a person was being abused. Staff were clear about their responsibility to report safeguarding concerns and knew how to do this, both within the organisation and externally.
- The provider had referred safeguarding concerns to the local authority for further investigation and had notified CQC.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- Where people required support to make sure they had enough to drink, records did not demonstrate that this was always in place.
- Where people's fluid intake was a concern, a fluid balance chart was used to monitor people's intake and, where necessary, output. This was not in place for all people who needed this, including for people fitted with a catheter. People who are catheterised require careful monitoring in case they begin to retain fluid and become unwell. However, we noted that people had access to drinks and these were promoted and regularly topped up.
- There was mixed feedback about the food. Three people were not clear about what meal they would be receiving, despite having a four-week menu which they chose from. The regional support manager explained that the wholesaler was sometimes unable to source certain ingredients which affected what the kitchen was able offer. The regional support manager assured us they would discuss this with people who used the service to clarify the issue.
- Otherwise feedback about the food was positive and the chef was knowledgeable about people's eating and drinking needs and choices. We fed back that the downstairs dining room, which was large and had a pleasant outlook onto the garden, was only used by one person. Staff told us this was a cultural issue within the service which had been made worse during the recent lockdowns. There were plans in place to actively encourage people to eat some of their meals together in future.
- Staff were attentive to people's needs during mealtimes and offered support sensitively to those who needed it.
- Oversight of people's weights was good. Where people were found to be losing too much weight or struggling to swallow food safely, staff promptly referred them to specialist healthcare professionals for advice and guidance.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Some people's healthcare needs were not fully met.
- We noted one person's nails were very long and had the potential to cause them injury. Staff confirmed they struggled to help the person with this, and the service had been unable to source a chiropodist. By the time we completed our inspection the person's nails had been cut and their care plan reviewed. Following our inspection, the service informed us that they had arranged for a chiropodist to visit people regularly.
- Another person required a particular aspect of their health to be monitored and recorded on their room folder. Records were completed but there was a lack of review of this person's room folder and staff were

not aware of a potential health concern until we queried it. This placed the person at risk of becoming unwell.

- Other healthcare needs, including oral care, were well documented and there was a record of healthcare appointments in people's care plans. People received support from healthcare professionals as and when needed, such as GPs, district nurses, speech and language therapists, dieticians and occupational therapists.
- Where people had acquired pressure ulcers or skin tears the service worked closely with the local district nursing team. Wound records were very good and showed people's wounds improving over time. One person told us, "I've seen the nurse and it's all healing up nicely. The staff here have been wonderful."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care, and support needs were assessed before they started using the service. Initial assessments determined whether the service could meet people's needs safely.
- Pre-admission assessments were used to draw-up care plans and risk assessments. The provider worked with people who used the service, relatives and health and social care professionals to ensure each person's needs were fully assessed and their choices documented.

Staff support: induction, training, skills and experience

- Permanent and agency staff received a structured and comprehensive induction. Staff had some face to face training and some online learning. One staff member told us there was a new focus on 'experiential learning'. They said, "We put ourselves in the residents' shoes." Staff told us they felt they had the knowledge and skills they needed to support people safely.
- Staff received support and supervision from senior staff. They were positive about the support from the regional support manager, who had been in day to day charge of the service in the absence of a registered manager. One staff member stated' "[The regional support manager] is very supportive and measured, which really helps the team."

Adapting service, design, decoration to meet people's needs

- There were handrails and signage in place to help people navigate their way around the service. The enclosed garden space was pleasant and access to the front of the building, where there was a main road, was restricted by a padlocked gate.
- There had been a programme of refurbishment in place and many communal areas had been newly decorated. Bathrooms were fully accessible and had also been refurbished.
- The downstairs sitting room and dining room were hardly ever used as people chose to remain in their rooms. Staff had a plan in place to actively encourage people, especially people new to the service, to use these spaces in the future and create a new culture.

Ensuring consent to care and treatment in line with law and guidance

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

- Staff understood the importance of gaining people's consent before they provided care and support. Records documented people's capacity to understand information and to make decisions in accordance with the structured MCA process. Where people lacked capacity, decisions were made in their best interests involving relevant health and social care professionals and, if appropriate, family.
- Care records documented that people's consent had been assessed relating to receiving specific care and treatment. Best interests decisions and capacity assessments were in place to establish a person's consent to a variety of matters including end of life care, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and COVID-19 testing.
- People who used the service confirmed to us staff always sought consent and would not proceed if they thought the person was unhappy. One person explained, "They always listen to me."
- One person, who had capacity to make their own decisions, had decided not to have a certain piece of safety equipment. This decision was respected and a risk assessment and guidance for staff put in place.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People who used the service were positive about the way the staff supported and cared for them. One person told us, "The [staff] are wonderful... We have a laugh and a joke. They are a tonic and so kind."
- We observed warm and friendly interactions and lots of joking and laughter. It was clear that staff knew the people who used the service well and were able to interact with them in meaningful ways. Staff were very attentive and anticipated people's needs well.
- People were treated with respect. Where they had made decisions about whether they preferred to be supported and cared for by staff of the same gender as they were, this was respected. Staff had received training in treating people with dignity and respect.
- Care plans included advice and guidance for staff about how to support people whilst maintaining their dignity and privacy. We observed this in practice.
- Some people had quite complex needs and behaviour which could be difficult to predict or make them unwilling to receive care. Staff showed a really good knowledge of how to encourage one person to let staff meet their needs.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to have a voice. Where people wished to do this, they were involved in decisions about their own care and took part in reviews of their care plan. People had signed their care plans and were knowledgeable about them.
- Care plans documented people's preferences about how they wished to receive their care. Plans clearly identified what was important to them, such as their preferred name and specific details about how they wished to be supported with their mobility.
- Staff were aware of people's rights. They encouraged people to make healthy choices about their meals and their health. However, where people had capacity, staff supported them with decisions, even if these could be considered unwise. Care plans reflected this.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has remained good. This meant people's needs were met through good organisation and delivery

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Each person's care plan folder contained detailed information about the specific care and support needs people had. These plans had been drawn up in consultation with the people they concerned and, where appropriate, their relatives.
- Staff, although sometimes a little unclear about exactly where to record information, were very clear about people's needs and were able to tell us about people's preferences in great detail.
- Since our last inspection the service has implemented 'Resident of the Day' during which care needs and records were reviewed and the focus was on that person and their needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People received information in a format they could understand. Signage helped people navigate their way around the building and care plans contained guidance about how to communicate successfully with people.
- Where people experienced hearing loss the service supported them to use and maintain hearing aids.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Since the COVID-19 lockdown restrictions had been in place, people who used the service had become more isolated, spending long periods in their rooms. This was already part of the culture for some areas of this service. The activities co-ordinator, along with the management of the service, had been actively trying to address this and forge a community feel within the service.
- There had been a focus on improving the variety of activities offered to people and further opportunities were being planned. We observed people taking part in some group activities. One person told us they liked a particular memory game saying, "It really makes me think!"
- The activities co-ordinator told us that a group of people had recently attended a local school assembly and a party was being planned with families to celebrate the queen's platinum jubilee. People were supported to go out into the local community.
- The activities co-ordinator had linked with staff in other services to share ideas and was very committed to increasing the opportunities for people to continue the hobbies and interests they had before coming to live

at the service. Those people unable or unwilling to attend group activities told us staff offered meaningful activities on a one to one basis, although some said this could happen more.

- There was a private social media page which families and friends could access. One relative told us they like to view this and see what different activities were being offered. They said staff encouraged their family member to take part as sometimes they initially refused but ultimately enjoyed themselves. The occasional newsletter kept families informed of life at the service when they could not attend in person.

Improving care quality in response to complaints or concerns

- There was a complaints policy and procedure in place. Complaints were recorded and managed in line with the provider's policy.

- Regular meetings for the people who used the service and relatives gave opportunities for informal matters to be raised. Relatives told us they felt able to raise issues with the current management and had confidence their concerns would be dealt with.

End of life care and support

- People's end of life wishes for their care were clearly recorded in their care plan, although one plan had yet to be completed.

- As people approached the end of their life staff told us they ensured anticipatory medicines were in place. These are medicines which aimed to ensure any pain or distress was reduced as much as possible.

- Staff received training in caring for people at the end of their lives as part of their induction but additional refresher training for permanent staff had not been provided recently.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to operate an effective system to assess, monitor and improve the quality and safety of the service or to mitigate risk. They also failed to ensure records were accurate and complete. Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems designed to monitor the safety and quality of the service were not always effective. Records relating to people's eating, drinking, pressure care and continence were not always completed, and effective oversight of the room folders was not in place. This meant we were not fully assured that people's health needs were being accurately recorded which placed them at risk of harm. Further work was required to ensure the organisations recording systems were more accurate and could be relied upon to give accurate information.
- There were audits in place to analyse patterns and trends. However, these did not always successfully resolve or reduce the risks over time and some basic oversight of records was not in place.
- Further work was needed to ensure recording systems and procedures accurately captured information and audited it effectively. For example, there was a catheter audit in place, but it was not being filled in accurately and had not identified that catheter records for one person were incomplete. Medicines audits had failed to identify that a medicine for one person had not been added to the MAR chart on their return from hospital. Neither of these omissions had, as far as we could tell, had any negative impact on the person but this poor monitoring posed a risk.

Systems had not been established to monitor and improve the safety of the service or to ensure records were accurate and complete. This placed people at risk of harm. This was a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to begin addressing the concerns we identified by introducing new systems and by reinstating some checking systems which had been discontinued in error.

- Other audits of the safety and quality of the service were good. There were good systems in place to monitor the safety of the environment and of health and safety equipment.
- The provider had been very mindful of the improvements needed at the service following the last inspection and had taken the decision not to admit new people to the service until they felt confident they could meet their needs. A strategy was in place to slowly begin to admit new people. The approach was sensible and designed to ensure staff had the time needed to accommodate new people.
- There was no registered manager in place as they had just left the service and there was a recruitment process in place to appoint a new one.

At our last inspection the provider failed to notify the Care Quality Commission of a relevant incident. This was a breach of regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- The provider had sent in monthly action plans since our last inspection in accordance with the condition we placed on their registration. These plans were transparent and of good quality and were submitted on time. We had been able to document the gradual improvement of the service over time. The service had notified us appropriately of significant incidents, as they are required to.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a focus on slowly changing elements of the culture at the service to promote a more inclusive feel. There were a number of initiatives to help centre the service with its community and also encourage people to mix a little more. Families, who had been away from the service for long periods of time, were starting to attend regularly once more.
- People who used the service told us they felt able to raise issues important to them. One person commented, "They listen to us." There were systems in place to engage people who used the service and seek out their opinions on a variety of issues. The service held regular meetings and there was a commitment to involving people in decisions about the running of the service.
- We reviewed the latest staff engagement survey and noted that comments were mostly positive about the recent changes and improvements in the service. A high percentage of staff had chosen to respond to the survey and their responses had been analysed at a senior level within the organisation.
- Staff were positive about the regional support manager who had been in day to day charge of the service in recent months. One staff member commented, "[Regional support manager] is very supportive, measured and really helps the team." Another said, "We are all pulling in the same direction. The managers have made changes for the better."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had been open and honest when things had gone wrong and took action to analyse incidents and share learning from this. The regional support manager accepted our onsite feedback about inaccurate recording and immediately put actions in place in order to improve recording.
- During our inspection process the managers were very open about the work the service still had to do. Following the error in medicines administration we identified they took robust action and shared the incident with relevant parties.

Working in partnership with others

- The service worked well in partnership with other agencies and healthcare professionals. Feedback we received from other professionals showed that this service was improving.
- There was evidence of partnership working between the services within the organisation, to share ideas and seek peer support.

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 17 HSCA RA Regulations 2014 Good governance The provider had not established systems to monitor and improve the safety of the service or to ensure records were accurate and complete. Regulation 17 (1) (2).