Four Seasons Homes No 4 Limited

Ivyhouse 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place over three days on 3, 4 and 11 February 2015. The inspection was unannounced.

We last inspected this service in September 2014 to follow up on concerns that had been brought to our attention. The home had two outstanding breaches of regulation identified at an earlier inspection but we did not specifically inspect these in September 2014. The breaches related to keeping the home clean and managing the risks of cross infection, and staffing. At this inspection in February 2015 we found the home had improved and was now meeting the requirements of the law regards staffing and prevention of infection. However the standard of cleanliness and odour control particularly on Daffodil Unit still required improvement.

Ivyhouse is a nursing home and is registered to provide support for up to 76 people. The home has four units. Rose Unit provides residential care for up to 18 people living with dementia, Cornflower Unit provides nursing care to 19 people, Daffodil Unit provides specialist nursing care to 18 older people who are also living with dementia and Tulip Unit provides specialist enablement

Summary of findings

support for an agreed amount of time, for up to 12 people who have received treatment in hospital. Tulip Unit also has four permanent residents who receive nursing care. At the time of our inspection 72 people were living at Ivyhouse. People all had their own en-suite bedroom and shared communal facilities on each unit including supported bathrooms, a lounge and dining room.

The home had a registered manager who was available during the 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.

People were supported by adequate numbers of staff and systems in place to check new staff before they were offered a position within the home were robust and protected people against the risk of staff that were unsuitable to work in the home.

Although arrangements were in place to obtain, administer and record that people had been given their medicines as prescribed we found some errors and not all people had received their medicines as prescribed.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Work had been undertaken to train staff and to start capacity assessments and make DoLS applications for people who required this, but this not always being undertaken in line with guidance and was not meeting the requirements set out in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People gave us mixed feedback about the food provided at Ivyhouse. Some people told us it was good and that they enjoyed it and other people told us that they did not. Some people who were at risk from not eating and drinking enough did not receive the full support they needed and arrangements to help them maintain a healthy weight were not effective.

We did not find that all people had been appropriately referred for healthcare support. Some aspects of care to keep people well and meet their needs were not adequate and had not ensured people had received the support they required.

Throughout our visit we observed kind and compassionate interactions between people and the staff supporting them. Whilst we observed many positive interactions when staff helped people to maintain their dignity we also saw some occasions where dignity was compromised.

People and their relatives had opportunity to be involved in planning their care, but people did not always receive care that met their preferred routines or respected their choice.

People we spoke with told us that complaints were dealt with promptly and to the satisfaction of the complainant.

The leadership and management of the home had improved and was becoming more effective at identifying and resolving issues, however it had failed to identify or act on the issues found at the inspection.

You can see what action we have asked the provider to take to address the breaches of regulations at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not live in a home that was clean or which smelt fresh.

Avoidable harm and indicators that people may be at risk or have experienced harm were not always identified and acted upon.

People were supported by adequate numbers of staff and assistive technology was being used to ensure people had the support they required, when they needed it.

Medicines were not always managed safely to protect people from harm. Although arrangements were in place to obtain, administer and record that people had been given their medicines we found some errors.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff that had been inducted to the home and trained.

The rights of people who may lack mental capacity to make decisions for themselves were not consistently protected.

People did not always have the support they required to eat and drink adequate amounts. The food and drinks provided were not always to an acceptable standard.

People did not consistently get their health care needs met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff that were kind and compassionate.

People had not always been supported to undertake their personal care to a good standard.

People's dignity and privacy was not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not be certain they would have their care delivered how or when they preferred.

Some interesting activities were provided but people spent long periods of time without occupation or engagement.

Summary of findings

There were systems in place to respond to concerns.

Is the service well-led?

Requires Improvement

The service was not well-led.

Whilst leadership in the home had improved people could not be certain they would always get consistently good quality, safe care.

Action had been taken to improve the culture of the home, to ensure there was an atmosphere of transparency and openness.

Significant changes had occurred in the leadership and management team of the home in the twelve months prior to the inspection. This had become established and had started to bring change and improvement to the home, but there were significant improvements still to be made.

Ivyhouse 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 was 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 the 3, 4 and 11 of February 2015 and was unannounced. The inspection was undertaken by one inspector and a pharmacy inspector on the first day. On day two of the inspections there were two inspectors and on the third day an inspector was supported by a Specialist Advisor who had specialist knowledge about the nursing needs of older people.

Before our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which the provider is required to send us by law.

During our inspection we spoke with people living at Ivyhouse, their relatives, the staff and some of the health and social care professionals who visit and support people living at this home. We used our Short Observational Framework for Inspection (SOFI) as a way of finding out about the experiences of people who were unable to tell us these because of their healthcare conditions.

To support our findings we looked at the records of 11 people's care, so we could see how specific areas of their care had been assessed, planned, provided for and recorded. We looked at the recruitment records of three members of staff, medicine management for 13 people and a selection of records that showed how the provider was monitoring the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in September 2014 to follow up on concerns that had been brought to our attention. The home had two breaches of regulation identified at an inspection in June 2014 which we did not specifically inspect in September 2014. The breaches related to keeping the home clean and managing the risks of cross infection, and staffing. At this inspection in February 2015 we reviewed these outstanding breaches and we found the home was now meeting the requirements of the law regards staffing. However the standard of cleanliness and odour control particularly on Daffodil Unit had not been maintained and failed to provide people with a consistently homely environment that was clean and hygienic.

We found that whilst the standards of cleanliness on three of the four units had improved this was not the experience of people throughout the home. The lack of effective management of cleaning on Daffodil Unit and in some hallways was more apparent. Staff advised that the unit had been cleaned on the morning of the inspection however we noted that there were very dirty carpets, the Unit smelt unpleasant and we found that some chairs were dirty and pressure cushions were soiled and wet and not fit for use. When these observations were brought to the attention of the registered manager action was quickly taken to provide additional cleaning. The systems and arrangements in place for keeping the service clean and checking that these arrangements had been effective were inadequate. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with all told us they felt safe. A range of comments included, “I feel perfectly safe”, “Oh yes, everything is fine here” and “Staff are always kind to us and I have never heard anyone be rough or rude.” Relatives we spoke with supported this and told us, “I am never in any doubt that my mum is safe and well” and, “Generally it has all been very good. I am pleased she is safe and particularly pleased there have been no falls.” People we spoke with told us they would feel able to raise any concerns about their safety and told us they would do this with certain members of staff they had a particular confidence in, or would speak to the nurse on duty.

Staff we spoke with were all clear about adult abuse, and were able to describe different types of abuse. The staff consistently told us what they would do to report abuse if they witnessed it or if it was reported to them. This was in line with the provider’s own policy and local guidelines. This would ensure matters of concern would be identified and responded to promptly.

Staff we spoke with were able to describe a wide range of activities they undertook each day to help keep people safe. Staff were aware of hazards within the premises and there were both formal checks taking place as well as staff observing for hazards and risks while undertaking their day to day work. Records we looked at showed that checks and servicing had been undertaken on all the necessary systems and equipment such as the fire alarm and hoists to ensure the premises and equipment were in good working order and safe for people to use.

We checked 13 people’s medicine records which had all been signed for the administration of medicines. Staff also completed a ‘Daily Medication Audit’ form to record that medicine records were accurate and that people had been given their medicines. However, when we checked people’s medicines we found discrepancies between the amount of prescribed medicines available and those that had been signed for as administered. Supplies of some medication had run out and although staff had ordered the medication when this had been noted the system in use had failed to identify that new stocks of the medication were needed. These medicine recording and administration errors had not been identified by the daily checks. We saw that people’s medicines were stored securely within the recommended temperature ranges for safe medicine storage.

The registered provider had developed a system to help identify the number of staff required depending on the needs and number of people living at Ivy House. The manager showed how she used this as a baseline for staffing and how she monitored and adjusted this to ensure there were sufficient staff on duty to meet people’s needs. We found that assistive technology aids including pressure mats next to beds or chairs were also being used. This enabled people to spend time alone in their room without staff supervision; however staff were alerted as soon as the person started to move to enable them to support or supervise them if required. During our inspection we observed that staff were busy but that

Requires Improvement

Is the service safe?

people did not have to wait unreasonable lengths of time for the support they required. People living at the home and relatives we spoke with about staffing told us, “I have a call bell. If I press it staff will come quickly”, and “Staff are kind, but always very busy. If you draw their attention to something they will respond but probably not immediately.”

We looked at the recruitment records for three members of staff. We found that robust checks had been made before staff were offered a position within the home. Staff we spoke with confirmed this.

Requires Improvement

Is the service effective?

Our findings

We looked at the work the provider had undertaken to ensure they were complying with The Mental Capacity Act 2005 (MCA). The act sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. We found that that the home had started to deliver training to staff and the staff we spoke with were able to describe their responsibility under the MCA and the way it impacted on the care they delivered.

Staff were able to show us the work they had undertaken to assess people in line with the MCA. We found the assessments were generic and did not look at people's ability to make individual decisions, but assessed them to either "have" or "not have" capacity. We saw partly completed Deprivation of Liberty Safeguards (DoLS) application in a number of people's care folders. The deprivation that had been identified, prompting a DoLS referral was not evident on the file and the nurse we spoke with was not sure what they would write. We saw documents that indicated that a person with capacity had not been asked about aspects of their care and if they were in agreement with the use of bed safety rails. Most staff were unable to tell us how they involved people or sought their consent in making decisions about aspects of their care which limited their freedom or choice. Before our inspection the manager notified us of an incident where a person had left the home without staff being aware. Discussion with staff at the time of the report and during our inspection identified that staff did not fully understand people's rights to make decisions for themselves when they have mental capacity, even when staff had believed that the decision made was unwise.

We found that the home was not complying with the requirements of the Mental Capacity Act 2005 and this was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the feedback and our observations about food, drinks and support at meal times varied across the four units of the home. Some people told us they found the food and drinks adequate and tasty, and their comments included, "It was very nice", and "The food is alright-good even." One relative we spoke with told us, "They always help her to eat and the food looks nice." Other people told us food and drinks were not good and their comments included, "There is plenty of room for improvement" and "Some days it is okay, some days it is inedible."

We observed that people did not always have the help and support they required to eat and drink, or to have a pleasant meal time experience. On Cornflower Unit we observed that the support at lunch time was chaotic. We saw the lunch time food arrive at the dining room in a heated trolley which staff served. We observed that the plated meals were left unheated for 10 minutes while staff went and got sauces and condiments. People were not offered a replacement hot meal. On Daffodil Unit we observed the morning refreshment trolley arrive on the unit at 11.55am. People were offered a drink and cake and people with diabetes were offered a banana. We then observed that 20 minutes later people were asked to move to the dining table as lunch had arrived. People with diabetes were given another banana as their dessert. We were concerned that the timing of meals and lack of planning showed a lack of skilled support to ensure that people received food and drinks that met their needs and made mealtimes a pleasurable experience.

Some people had been reviewed by a dietician or Speech and Language therapist. The guidelines in place for people's nutrition and for altering the texture of people's food was being followed for the people we looked at in detail.

Some people had health related conditions that meant the staff needed to maintain records about the food and drinks they had been offered and taken. We found there were significant gaps in these records. One person whose care we followed in detail on Rose Unit had significant gaps in their records and the person was unable to tell us if they were hungry or thirsty. During our visit we met a visiting health professional who was concerned the person they were visiting was de-hydrated and during their visit had managed to support them to drink a large amount of fluid. Some people had been identified as requiring regular weight monitoring to ensure they were receiving an adequate intake of food. We found there were significant gaps in these records and that the staff had not always undertaken the weight monitoring at the intervals set by them or required by a health professional. Records we looked at showed that some people had lost weight and that although this weight loss had been recorded staff had

Is the service effective?

not always identified this as an issue and sought advice from the relevant health professional. Our observations, discussions with staff and health professionals and the providers own records failed to show that people were always getting the help they required to eat and drink adequate amounts to maintain good health. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were supported by staff they liked and who they felt met their needs. A relative told us," We're very happy with the care. All the staff seem to know what they're doing." We found evidence that some people had been supported to maintain good health and staff shared with us examples of people's existing conditions improving when they moved into the home. Our observations showed that whilst some staff were able to support people with a wide variety of needs there were some aspects of care and support where staff did not demonstrate skills and abilities needed. We observed that one person had extensive bruising on their arms. We asked staff what might have caused this and what action had been taken. Staff we spoke with confirmed they were aware of the bruising but could not confirm any action that had been taken. We looked in the person's care records. No record had been made about this bruising and action had not been taken to seek some support for the person. After drawing this to the registered manager's attention medical advice was sought for this person. However failing to act upon these bruises had not ensured the person's well-being.

Some staff we spoke with had worked in care for many years and had obtained skills and experiences over that time. Other staff told us they had been trained or supported by senior staff to obtain the skills they needed either by attending training or by observing more experienced members of the team. Staff confirmed that they had received an induction which enabled them to provide care and support to people living in the home.

The home had a large work force to reflect the number of people they supported. We found that detailed training plans showing the training staff required and had received had been developed and maintained. The manager was able to describe how people were made aware their training was due and the systems in place to monitor this. Whilst the aim of this had been to ensure that staff had the skills they needed to work safely and to meet the needs of the people they were supporting it had not been wholly effective.

People had a wide range of physical and psychological health care needs and we looked at the plans in place showing how these had been assessed, planned for and kept under review. We found some care plans were very detailed and reflected the person's needs well. However other care plans had not been updated when the person's needs had changed. We found two examples of this in relation to catheter care and eating and drinking.

We looked to see if people who needed them were wearing or had available their glasses, hearing aids and walking aids as they required. With the exception of one person on Tulip Unit this was the case. The person told us they usually wore dentures and hearing aids. The person's teeth had been lost in hospital, but in the six days the person had been at the home they had not been consulted on their diet to ensure they could eat. The questions raised during the inspection prompted staff to look for the person's hearing aids, this support they had not previously been offered.

We found that some people had been offered regular appointments with the doctor, chiropodist optician and dentist. For other people these appointments had not been made available. People told us and records confirmed that doctors and medical attention were sought when people became unwell.

Requires Improvement

Is the service caring?

Our findings

Staff we spoke with were aware of the need to help people maintain and protect their dignity. During our inspection we observed some very good practice where staff offered to cover ladies legs, to shut doors to protect privacy and we heard staff speaking discreetly to people about matters personal to them. We also observed and heard some practice which was not respectful of people's privacy and dignity. This included not shutting a toilet door when a person was using the toilet in full view of visitors to the home and failing to help people change their clothes when it was observed they were not fitting well. We heard some staff ask people in a loud voice if they needed the toilet, or ask them questions about their care, their diet or pain they were experiencing which were questions people might have preferred to have been asked discreetly or in private.

The bath on Rose Unit had been condemned as unfit for use in January 2014. In June 2014 we were informed that agreement had been made to purchase a new bath. At this inspection we found that a new bath still had not been obtained, and that people wishing to have a bath were required to do so on another of the units within the home. This unit only had a shower facility available and people had not been aware of the lack of this facility on Rose Unit when they moved into the home.

We heard three separate incidents of people being called by different names. In two instances we asked the person what they liked to be called and we looked at two people's care records. We found that staff were not always using people's preferred name, and saw that some records showed inconsistent references to the same person.

People we spoke with told us that staff were kind to them. People's comments included, "There are some lovely ladies here, and lads," and "The carers and nurses are always nice to me." This was further supported by relatives we spoke with who told us, "There is always a nice atmosphere in the home" and "They are a lovely lot of staff, so kind. I have never seen or heard anyone being spoken to harshly or inappropriately." In the enablement Unit (Tulip) we heard staff working in a way that was particularly focussed on the comfort and welfare of the people they were supporting. For example we regularly overheard staff asking, "Can I help you" and "What would you like me to do to support you?"

In three of the four units we inspected we found that staff were aware of people's life history and important members of their family. We found that staff had got to know this over time and that their knowledge was supported by written records in people's care files. People staying in Tulip Unit, which was focussed on enablement, were in the home for short term support. Staff did not have the opportunity to get to know people in the same amount of detail, however we found that some basic details such as people's preferences in regards to food and drinks, and times people wished to retire to bed for example had not been determined, and in these areas we found some people had not received the care and support they needed, in the way they preferred.

People we met on Daffodil and Cornflower Units had not all been supported to undertake or maintain personal hygiene and to attend to their appearance. Some people had not been supported to be well groomed as they wished or in line with their personal preferences. Some people were unable to tell us if they were happy with their appearance and we looked at their care plans and records of care to see what had been planned for and agreed. We saw that people had agreed as a minimum to a bath or shower once each week. Five records we viewed showed that four people had not been offered a bath or shower for four weeks and for one person it was seven weeks since they were last recorded as having a bath or shower. People and relatives we spoke with told us, "[my relative] is always a bit grubby, but overall they are okay," and "I know I look a mess. I am hoping for a shower. I guess they will get round to it." On Tulip Unit we observed that there was a higher ratio of staff to people and this had resulted in people having greater access to support to meet their personal care needs. It was noted that on this unit staff had helped people personalise their appearance for example by wearing their jewellery.

In all of the units of the home we saw people showing some distressed behaviour at various times. We found that staff responded to this quickly and did their best to reassure people. There was no guidance available for staff about how to respond consistently to individual people's distress.

We observed staff offering people the opportunity to make decisions for themselves. Examples we heard included staff offering choices such as where people would like to sit, what they would like to eat or drink, if they would like a

Requires Improvement

Is the service caring?

bath or shower or what they would like to wear. Some people told us they had made specific requests as part of their care plan, in some instances we saw this had been respected- for example people who did not get up until mid-morning or lunch time. Other people were frustrated that this request was often not honoured. One man told us they had requested a shave on alternate days but that they were only shaved on a Wednesday when it was their turn for a shower. It was a Wednesday and we saw that later in the day the man had been supported to shower, shave and change their clothes. We returned to the home the following Wednesday and the person told us they had not been shaved or showered since the previous Wednesday which was reflected in the providers own records. Again the person was supported to shave and shower that day. This failure to support people in the way they have expressed and wished mean people may not feel listened to, respected or that their views are acted upon.

The home had recently altered the nurse call system. We found that the nurse call bell could be heard in all areas of the home and not just on the unit where the person calling for help was based. People in the home and some relatives commented on the increased noise and stress this at times had introduced to the home. One person told us," The buzzer [nurse call system] is a bit much. It keeps going off. I can hear it at night and sometimes it feels like it just goes on and on." During our inspection we found that the nurse call alarm did sound very frequently and sometimes this did go on for extended periods, especially when the front door bell rang.

We observed that each of the four units had some adaptations that enabled people to maintain their independence. We saw that the home had purchased and were using a wide range of different cups, cutlery and crockery. This enabled people to eat and drink as independently as possible. The enablement unit (Tulip) had a wide range of equipment and adaptations to enable people to practice and regain skills they may have lost after being ill or in hospital for a long time.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with were unable to confirm that they received individualised or person centred care. People told us they were generally happy with the care and support they received but that they felt most people were treated alike. One relative told us that during her earlier life their mother had paid particular attention to her appearance. They went on to tell us, "Mum is helped to stay clean but they do nothing to help her look pretty. Her hair is always a mess; she is never helped with make up or jewellery." Another person told us they did not usually like the hot drinks that were served. Staff had not identified this, and despite the person being recorded as refusing many of their drinks staff had not explored this further with the person.

We observed that the opportunity to participate in interesting activities varied between the units and on different days of the inspection. We observed some very good practice where staff sat and chatted with people, or undertook games with people in a small group. This was particularly evident on Tulip Unit where the staffing ratios were higher. We observed some large group activities including listening to music and entertainment. However we also observed times when staff missed opportunities to engage with people while they were observing or supervising communal areas of the home.

People were supported to maintain links and relationships with people who were important to them. Throughout the inspection we observed and spoke with family and friends of people living at Ivyhouse. Visitors told us they were made to feel welcome and often offered refreshments. One visitor told us that members of their family often visited late in the evening, and looking at the records of visitors maintained by the home we could see that visitors were able to visit their friend or relative at any time.

The registered manager was able to show us the records demonstrating the action taken in response to concerns and complaints. We found that the manager responded to people quickly to let them know what action she was planning to take and that detailed feedback was provided when the complaint investigation was complete. We spoke with one relative who had raised concerns about a specific incident that had occurred at the home. They told us they felt the matter had been dealt with quickly and robustly and were happy with the action taken. Other relatives we spoke with told us they had never needed to make a complaint but if they did they would feel confident to do this. One relative told us, "She [my relative] has been here for years and I have never felt the need to make a complaint. If I did I would feel more than happy to speak with the manager."

Is the service well-led?

Our findings

At the last inspection of Ivyhouse we found that the home had breached some Regulations of the Health and Social Care Act 2008. Whilst this inspection again identified repeated breaches of the Regulations we also noted signs of improvements throughout the inspection in all areas of the home. The management of the home had changed frequently in the past but the management team that was in place at the inspection was settled and established. The manager was open to the inspection process and honest about the work they had undertaken and what they felt they still had to do.

The registered manager and other senior staff within the home had developed a range of quality assurance tools that had been in place for some months. We found the on-going use of these tools had helped to identify some areas for development which when addressed had resulted in the standard of care improving, however the not all of the audits had been effective as significant issues identified during the inspection had not been identified by the manager or the provider. The provider has failed to ensure that effective systems were being used to protect people from risks relating to their health, welfare and safety. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered manager and provider had taken positive steps to improve the openness and culture of the home since our last inspection. Relatives we spoke with who had been visiting the home for some years told us they had recently felt the atmosphere within the home change. Relatives told us, “This is a great unit. The staff are all well trained, it is a very good team” and “This manager is very approachable. Either the manager or the nurse on shift nearly always ask me if I am okay, if I have any concerns or if there is anything I would like to talk through.” Staff we spoke with further supported this and told us, “This is a home where historically things have been brushed under the carpet. It is now much more open,” and “This is the best home management we have ever had. I feel comfortable to talk to the manager’s, and I find the manager addresses problems quickly and is approachable.” One of the healthcare professionals we spoke with told us they had seen the home gradually turning round over time. They told us they had seen a greater focus on the well-being of the people living at the home and found the changes had been applied consistently. Everyone we spoke with told us they found the management team of the home approachable.

We found that new systems to ensure people living, working and visiting the home were kept up to date with news, changes and opportunities had been introduced, some of these were initiatives had been suggested by staff. These included new notice boards, meetings and a suggestion box.

The manager had developed a link with a specialist team that was helping to promote best practice for people living in care homes that were experiencing mental ill health. As well as the specific developments that would support people with mental health needs the work was focussing on improving the culture and leadership within the home. Staff we spoke with had found this a positive piece of work and the manager was able to describe some of the benefits people living and working at the home had already experienced and should go on to enjoy. The registered manager had developed stronger relationships with the multi-disciplinary team who were able to advice on specific initiatives in certain fields of care and nursing.

We saw that a relationship had been made with a local hospice that had been able to provide support and training to staff in the needs of people as they approach the end of their life. The organisation operated a development programme for services that specifically support people living with dementia. We found the home had signed up to the programme and was looking at developments and improvements it could make that would enhance the quality of service, and help them achieve the “Pearl” programme.

The provider’s regional manager and registered manager were complying with all the conditions of registration and had ensured that certain events that occur within the home had been notified to the commission as required by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People did not benefit from effective systems that monitored the quality or safety of the service. Risks relating to people's health, safety and welfare had not all been identified and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Not all of the people were provided with the support they required to ensure they would have adequate amounts to eat and drink.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not supported by staff who fully understood their responsibilities in respect of consent under the Mental Capacity Act 2005.