

Davard Care Homes Limited

Welshwood Manor

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?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on the 20 September 2018.

Welshwood Manor is a care home which provides accommodation, personal care and nursing for up to 34 older people who may also be living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 34 older people with nursing needs in one adapted building comprising of two floors. At the time of our inspection there were 19 people living at the service.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was in the process of standing down from their post and a new manager recruited who would be starting their employment in October 2018.

At the last inspection carried out in November 2016 the service had an overall rating of 'Good'. At this inspection we found there was a need for improvement and the overall rating of the service was now 'Requires Improvement'.

Whilst we found a number of health and safety audits in place, there was a lack of overall governance systems to ensure the safety and quality of the service was maintained and risks to people's safety identified with steps taken to mitigate these risks. For example, in relation to the ongoing assessment and review of risks, management of people's medicines, staff training and the management of incidents and accidents. The lack of supernumerary hours allocated to the registered manager to enable them time away from working 'hands on' shifts had impacted on their ability to have sufficient time to support effective oversight, planning and development of the service. The registered provider told us this shortfall had been identified and the new manager, would be employed to work only supernumerary hours to enable them time to develop the service and improve systems and processes to ensure effective oversight of the service.

There was an open and transparent culture with a willingness to learn from incidents and respond to the shortfalls we identified at this inspection. For example, environmental risks we identified such as unsecured wardrobes, risks of scalding from hot surfaces and lack of bed rails checks were responded to promptly once brought to the registered manager's attention.

Staff had been trained in safeguarding and understood their responsibility to protect people from avoidable harm and abuse. Care was provided from a stable staff team with enough staff of varying skills on duty to support people's needs. Staff had been recruited as required with relevant checks carried out before they

started work.

The premises were well maintained, clean, secure with infection control systems in place. Work had been carried out to improve the premises with building extensions to create larger rooms for people with refurbished bathrooms and en-suites.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. People received care and support from kind staff who sought their consent and respected their privacy and dignity.

People were protected from the risk of poor nutrition and dehydration. Health care needs were met and where specialist support was needed referred in a timely manner to other healthcare professionals.

People's needs were assessed on admission to the service and care plans in place to guide staff in meeting people's needs. Support was flexible and staff responded to individual needs and enabled people to access activities of their choosing. People were consulted as to their wishes in planning for their end of life care.

There was a complaints policy and process in place. However, there were no complaints recorded as received. People told us they would not hesitate to complain and felt confident their concerns and complaints would be responded to appropriately.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not consistently safe.

There was a lack of systems in place which would ensure effective oversight of medicines management and identify administration errors.

Further work was needed to ensure risk assessments and management plans were in place to guide staff in steps they should take to mitigate the risk of harm.

Staff had been trained in safeguarding and understood their responsibility to protect people from avoidable harm and abuse.

There were enough staff of varying skills on duty to support people safely.

There were safe systems in place for the recruitment of staff.

Is the service effective?

Good 

The service was effective.

Staff received training relevant to their roles.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to other healthcare professionals promptly when needed.

Is the service caring?

Good 

The service was caring.

People were supported by kind and caring staff who knew them well.

People's independence was encouraged and their rights to privacy and dignity upheld.

People were encouraged to express their views and to make choices.

Is the service responsive?

Good ●

The service was responsive.

People's needs were assessed on admission to the service and care plans in place to guide staff in meeting people's needs.

Support was flexible and staff responded to individual needs and enabled people to access activities of their choosing. People were consulted as to their wishes in planning for their end of life care.

There was a complaints policy and process in place.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Whilst there was a number of health and safety audits place, there was a lack of overall governance systems in place to ensure the safety and quality of the service was maintained.

The lack of supernumerary hours away from working 'hands on' shifts impacted on the registered manager's ability to have sufficient time to support effective oversight, planning and development of the service.

Welshwood Manor

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 was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk in relation to the unsafe management of medicines. This inspection examined those risks.

This inspection took place on the 20 September 2018 and was unannounced.

The inspection team consisted of two inspectors including a pharmacist inspector, a specialist adviser and one expert-by-experience. On this occasion our specialist was a nurse with experience with working with older people, including those who have lived in residential care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, and their expertise was in the care of older people.

Prior to our inspection we looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

We spoke with 11 people who could verbally express their views about the quality of the service they received and five people's relatives. We observed the care and support provided to people throughout our inspection.

We spoke with the registered manager, the registered provider, one nurse, the administrator, three care staff and the cook.

To help us assess how people's care and support needs were being met we looked at records in relation to seven people's care. These records included their care plans, management of medicines and monitoring records in relation to the care support provided. We also reviewed records relating to three recently recruited staff recruitment files, staff rotas, staff training and systems for monitoring the quality and safety of the service.

Is the service safe?

Our findings

At the last inspection in November 2016 this domain was rated 'Good'. At this inspection we found some improvements were needed and this domain was now rated 'Requires Improvement'.

A recent serious incident had identified gaps in the management of people's medicines. There was a lack of systems in place which would ensure effective oversight of medicines management and identify administration errors. We found there was no clear process in place for reporting medicine errors or 'near misses'. This meant there was no oversight of the medicine incidents occurring within the service and no evidence of shared learning taking place. Other than participating in a daily check of stock when administering medicines, the registered manager did not conduct any other medicine audits. A recent external audit conducted by the supplying pharmacy also identified a number of improvements needed.

We reviewed 18 people's medicines and found there were only occasional gaps where staff had not signed for the administration of a cream or ointment, all other medicines had been administered as prescribed. Appropriate records were made if people did not receive their medicines for any reason. People had a photograph to identify them as part of their medicines record and allergies were documented. However, handwritten additions or changes to the MAR charts had not always been signed and checked by a second member of staff. One medicine that was required to be administered separately from other medicines and caffeine drinks was not being given as prescribed as it was being given in the morning along with all other medicines.

There were no protocols for the administration of 'as required' medicines available. These protocols provide guidance to staff as to when it is appropriate to administer medicines that are not required regularly. This included medicines used for low blood glucose, agitation, psychosis, analgesics, sleeping tablets and laxatives.

When people are nearing the end of life they may require medicines to be administered, prescriptions had been written up in anticipation, however there was no guidance for staff as to when it would be suitable to start the administration of these medicines. There was no recording in place to ensure that pain relief patches used as part of this care plan were rotated appropriately to protect people from the risk of harm according to the manufacturer's instructions.

All medicines were available, suitable for use and securely stored. Medicines requiring cold storage were kept in a designated refrigerator, however monitoring of the refrigerator did not include a record of the minimum or maximum temperature as is recognised good practice.

Controlled Drugs were suitably and securely stored. An external audit had raised the issue of the CD cabinet not complying with the Misuse of Drugs (Safe Custody) 1971 Regulations as the cupboard was not attached to a masonry wall using rag bolts. Controlled drugs are medicines that require additional controls because of their potential for abuse and are required to be stored safely, securely and additional records kept of their use. One medicine that was for single use only had been kept for further use. This meant the medicine was

not being stored and administered as prescribed.

People were supported to administer their own medicines if they chose to do so. For example, some people were applying prescribed creams independently. However, there was no assessment of risk in place in accordance with the provider's medicines management policy.

The shortfalls identified demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were processes in place to manage some environmental risks but not all the areas we identified as part of this inspection. For example, we observed a number of wardrobes which were not secured to the wall in people's rooms and could easily fall forwards with the potential to cause serious injury. We discussed this with the provider who took immediate action on the day of our visit to fit brackets to secure all wardrobes to the wall. Further work was needed to provide risk assessment guidance to staff in relation to the risk of scalding from access to hot surfaces. A number of unprotected radiators were found in people's rooms and corridors. The registered provider showed us documentation which confirmed that radiator covers had been ordered. They also told us shortly after our visit, the risk of scalding had been assessed and action taken to mitigate the risk to people.

Risks assessments were in place to identify the risks to people's safety. These included risks to people from inadequate food and drink, developing wounds such as pressure ulcers and skin tears; and the risk of choking. In relation to the safe moving and handling of people, care plans identified the number of staff required to assist the person, but did not always specify the equipment needed to do this safely. For example, one person requiring a hoist to mobilise, their care plan stated they required assistance of two staff, but did not specify the type and size of the hoist sling required and which loop staff should use to prevent the risk of falls from this equipment. People did not have individual slings provided. This meant people were at risk of injury from falls if the incorrect size of sling was used. This also presented a risk of cross infection if slings are used for more than one person.

Not everyone with a bed rail in place to prevent the risk of falling had a bed rail risk assessment in place and regular checks of bed rails carried out. For one person who had consented to the use of bed rails and bumpers to prevent the risk of entrapment, the bumpers were not in place. We discussed this with staff who immediately carried out a review of bed rails in place and installed protective bumpers where needed.

There was a system for recording accidents and incidents. However, these did not contain body maps as is recognised good practice to enable staff to record where on the body any injuries had been sustained or unexplained bruising. We also noted that where the accident/incident reporting system required the registered manager to evidence their review and record any actions required, this was left blank.

The shortfalls identified demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines that required additional monitoring with blood tests were appropriately managed and blood glucose was being routinely monitored for people receiving insulin. Appropriate action had been taken if their blood glucose was low.

Staff had been trained in safeguarding and understood their responsibility to protect people from avoidable harm and abuse. Staff understood their responsibilities to challenge poor practice and to report any concerns to a senior member of staff. One staff member told us, "If I was concerned I would go and tell the

manager. I would not doubt they would deal with the situation and take action."

There were enough staff of varying skills on duty to support people safely. People told us and we observed there were sufficient numbers of staff available to provide the support required to meet people's care and support needs. People received care from a stable staff team which meant they received consistency of care from staff who knew them well. We observed the deployment of staff was suitable to meet people's care and support needs in line with information documented within their care plan.

People told us they were provided with care and support in a timely manner and staff were always at hand within communal areas. One person told us, "The staff always come quickly when I press my alarm, I've never had to wait too long." Another person said, "Staff are always there when you need them. It can get a bit higgeldy, piggeldy if someone is off sick but they try their best." The registered manager and staff confirmed suitable arrangements were in place to address staffing shortfalls and these were managed from within the staff team to avoid the use of agency staff.

Staff were recruited in a way that protected people. Recruitment files viewed and discussions with staff showed us that appropriate checks had been carried out prior to the start of employment. This included gaps in employment history identified, and references from the most recent employer obtained. Checks were in place with the Disclosure and Barring Service (DBS) to establish if staff had any criminal record which would exclude them from working in this type of setting. References and identification checks were also completed.

People assessed at risk of falls from either climbing over the bed rails or getting out of bed had their beds lowered to their lowest positions, crash mattresses and movement sensors were also in use. Regular day and night time checks on people at risk were in place with records maintained. One person with a floor sensor mat in place told us, "I can be very naughty and forgetful sometimes when I do not use the call bell and walk to the toilet. When I step on the mat it sets off the alarm and the nurse comes in immediately to help me."

Staff received training in health and safety, first aid, fire safety and food hygiene. Personal emergency evacuation plans (PEEPS) provided guidance for staff which described the support each person would need to keep them safe in the event of an emergency.

People were protected by the systems in place for the prevention and control of infection. The premises were well maintained. There had been extensive building works carried out since the last inspection including refurbished bathrooms and en-suite facilities. The service was found to be clean and free from offensive odours.

Equipment was clean, secure and properly maintained. Staff told us and records confirmed that staff received infection control training, maintained cleaning schedules and understood their responsibilities for maintaining appropriate standards of cleanliness and hygiene to protect people from health acquired infections. The service maintained a five star rating for food safety management and kitchen hygiene standards.

Is the service effective?

Our findings

At the last inspection in November 2016 this domain was rated 'Good'. We found at this inspection the service maintained their rating as 'Good'.

Staff knew people well and everyone we spoke with said staff provided support with skill and knowledge.

Staff received a variety of training relevant to their roles and responsibilities. Nursing staff received updates including training in support of people's nursing needs at the end of life. For example, updates on the use of syringe drivers to administer pain relief medicines. However, further work was needed to evidence staff including nursing staff received regular supervision to enable them to discuss their training and development needs.

Staff told us and the staff training matrix reviewed showed, staff had received training in the safe moving and handling of people. The registered manager told us this training had been provided by a member of staff who had recently left the service. It was evident from discussions with the registered manager and registered provider that no checks had been carried out to ensure this person was qualified to provide this training and if so maintained accreditation with regular competency assessment as required. We also noted from the staff training matrix reviewed that several staff had not received annual refresher moving and handling training as required. We discussed this with the provider who shortly after our visit told us moving and handling training for staff with an accredited external trainer had been booked and scheduled to start in October 2018.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records showed that each person who used the service had their capacity to make decisions assessed. At the time of our inspection no person at the service was deemed to lack the capacity to make day-to-day decisions. Furthermore, no person at the service was subject to authorisation under the Deprivation of Liberty Safeguards.

People told us and we observed that staff understood the importance of giving people choices and respecting their wishes. People were observed being offered choices throughout the day and these included decisions about their day-to-day care needs. People told us they could choose what time they got up in the morning and the time they retired to bed, what clothes they wished to wear, where they ate their meals and whether or not they wished to participate in social and leisure activities.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. We saw that staff were vigilant in supporting people to have access to plenty of fluids. We received only positive comments about the quality of the food provided. Comments included, "The food is wonderful, always well presented and tasty", "There is plenty to eat, the cakes are home made. If you don't like something on the

menu there is no quibbling and alternatives are offered." And, "You couldn't wish for better, the food is truly fabulous. I have a lot of favourite meals here so I seldom get disappointed."

People's nutrition and hydration needs had been assessed to support their wellbeing and quality of life. We saw that the risks of people receiving inadequate food and fluid were effectively managed. Malnutrition assessment tools which were in use and people's weights were regularly monitored. We saw that where required professional advice was sought promptly in the event of weight loss when sudden or unexplained. Care plans contained detailed information to guide staff as to the support required for people at risk of choking, including the required consistency of food. This was also available to kitchen staff involved in the preparation of meals.

Meal times were well managed, calm and there were adequate numbers of staff available to support people who required support with eating their meals. Staff assisted people to eat at their own pace and encouraged them with explanations of what they were eating where this was required.

People told us their healthcare needs were well managed. One person told us, "My ear is sore today, I am going to speak to someone about it. They always follow things up." People had access to local healthcare services and healthcare professionals to maintain their health and wellbeing. For example, support to attend hospital appointments, access to a GP, dieticians, diabetic nurses and speech and language therapists.

Care records showed healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare professional visits and appointments.

The registered manager told us they were part of a new national initiative, the 'Red Bag Care Home Scheme'. The aim of this initiative is to promote and improve communication and relationships between the care service, ambulance crews and NHS Hospital. This enables relevant information about a person to be passed on and shared; and therefore, improving the person's experience of care and quality of life.

Is the service caring?

Our findings

At the last inspection in November 2016 this domain was rated 'Good'. We found at this inspection the service maintained their rating as 'Good'.

Everyone we spoke with was satisfied with the care and support they received. One person told us, "The staff are lovely, so kind and so helpful. We are well looked after." Another said, "I am only here a short while, for respite, but I would not hesitate to come back again. They [staff] have been wonderful to me, I could not get better treatment if I was the queen. The care is second to none."

People told us and we observed they valued their relationships with the staff and spoke positively about individual staff members. We observed staff had a good rapport and relationship with the staff who supported them. We saw that people and staff were relaxed in each other's company and it was clear that staff knew people very well. People were addressed by their preferred names and staff interacted with people in a kind and compassionate way, taking the time to listen. One person told us, "They have a laugh with us, they say 'come on let's see that smile', I know each one of them by their name." Another said, "Overall the staff are polite. Generally, I can communicate well with all the staff and the one who comes most regular to me is very good."

People were supported to express their views and to be involved, as far as possible, in making decisions about the care and support to be provided. People and their relatives had been given the opportunity to provide feedback about the service through regular reviews and through the completion of annual questionnaires.

People told us their personal care and support was provided in a way which maintained their privacy and dignity. They told us they were treated with courtesy and respect by staff. Our observations showed that staff respected people's privacy and dignity. We saw that staff knocked on people's doors before entering and staff were observed to use the term of address chosen by the individual. One person told us, "If I want to be left alone they [staff] respect this. I like my own company and enjoy the peace and quiet. I've never been one to mix in a crowd." People who needed support with personal care were assisted discreetly to protect their modesty. For example, staff spoke quietly with people about matters relating to personal care to respect their dignity.

People were supported to maintain their independence and personal appearance to ensure their self-esteem and sense of self-worth. People were supported to wear clothes that they liked, that suited their individual needs, including jewellery of their choice. One person told us, "I didn't like it at first, but I am slowly settling in. Staff have gradually been helping me get my independence back, I wash myself and do my own washing."

People were supported to maintain relationships with others. Relatives told us there were no restrictions as to when they visited and they were always made to feel welcome by the registered manager and staff. One relative said, "They are warm and welcoming, you just know you can arrive whenever you like and this would

not be questioned. There are no restrictions."

Is the service responsive?

Our findings

At the last inspection in November 2016 this domain was rated 'Good'. We found at this inspection the service maintained their rating as 'Good'.

Suitable arrangements were in place to assess the needs of people prior to admission to the service and they and their relatives were involved in this process. This ensured the service was able to meet the person's needs and provide sufficient information to guide staff. People and their relatives told us that an assessment of their needs had been carried out before they came to stay at the service. For one person recently admitted to the service we saw that an assessment of their care and support needs had been carried out. The information obtained following the assessment of their needs, had been used to develop a personalised care plan which described for staff, guidance to provide safe and appropriate care.

Care plans covered all aspects of a person's individual care and support needs, focussing on the care and support to be delivered by staff, what was important to the person and their personal preferences as to how they wished to be supported. For example, such as what time they wanted to get up and go to bed as well as how they wished to spend their time. However, some care plans were brief in detail with a lack of information such as guidance for staff in the safe moving and handling of people and some lacked evidence of regular review. The registered manager and provider told us they were in the process of looking at implementing a new care planning system which they anticipated would improve the quality.

People had been consulted as to their wishes in planning for their end of life care. Advanced care planning documents had been completed setting out people's preferences for end of life care, including their spiritual and religious beliefs and arrangements after their death.

We monitored people who were in receipt of palliative/end of life care. Where agreed, people had a Do Not Attempt Resuscitation (DNACPR) order in place. A DNACPR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR).

Where needed, people had pain relief medication prescribed including anticipatory medicines, as and when required medicines available to them. However, there was no recognised pain management tools in place which would guide staff in the assessment of pain for people who may be unable to verbally communicate if and when pain relief medicines were needed.

For people being nursed in bed, records confirmed staff provided regular fluid and mouth wash and repositioning for people at high risk of developing pressure sores.

One person diagnosed with a life limiting condition told us, "I am fully involved in my care. I have many professionals including people from the hospice who visit me regularly. I have regular counselling. I have regular chats with the staff, the manager and the owner. I am confident that I won't get better care than this anywhere."

A weekly programme of activities was provided and communicated to everyone. Activities included, food tasting sessions, exercise classes, bingo, crafts and outside entertainers as well as a local church visited. One person said, "I like to be outside in the garden, they give me freedom to grow some vegetables. We've had a bumper crop of tomatoes this year." Another person told us "I like to spend time playing scrabble or bingo. The staff spend time chatting with you. We also have people who entertain us, like singers which we all enjoy."

People told us that staff respected their wishes when they wanted to be alone and encouraged those who enjoyed the company of others to participate in group activities. Care plans were limited in describing people's personalised needs in relation to their social and emotional care and detailing those people important to them.

There was a complaints policy and process in place. However, no complaints had been received and recorded since our last inspection in November 2016. People told us, "My son has made a complaint on my behalf. It was really about staff knowing how to talk to people in a respectful manner. They did listen, and it has improved. I wasn't afraid of doing it myself, but he has power of attorney", "I would not hesitate to complain if I was unhappy about anything and I am confident I would be taken seriously." Another said, "This is a truly remarkable place where your opinions matter and you are listened to."

Is the service well-led?

Our findings

At the last inspection in November 2016 this domain was rated 'Good'. At this inspection we found some improvements were needed and this domain was now rated 'Requires Improvement'.

Whilst there was a number of health and safety audits in place, there was a lack of overall governance systems to ensure the safety and quality of the service was maintained. For example, in relation to clinical governance, the management of people's medicines, staff training and the management of incidents and accidents. The current arrangements were not as robust as they should be and improvements were needed. The current systems in place had not identified all the areas for improvement we found as part of this inspection. Whilst we acknowledge the registered manager has responded and taken action during our inspection to rectify some of the shortfalls we identified, the risks to people from receiving unsafe care had not been previously identified prior to our visit and mitigated.

The registered manager told us they did not have any supernumerary hours allocated to them as they worked permanent 'hands on' shifts as the nurse in charge on a daily basis. This they said had impacted on their ability to have sufficient time to support effective oversight, planning and development of the service. They also told us they would shortly be stepping down from their role but would continue to work at the service as a nurse. The registered provider told us a new manager had been recruited and would be starting their employment in October 2018. They said the new manager, would be employed to work only supernumerary hours to enable them time to develop the service and improve systems to ensure effective oversight of the service.

It was evident from our discussions with the registered manager, the registered provider and staff team that there was an open, transparent culture with a willingness to learn from incidents. Staff, people who used the service and their relatives were all complimentary about the registered manager. Comments included, "The manager is lovely, very approachable and cares about the people who live here", "[Manager] is great, if I had any concerns I would go straight to him without hesitation, he is so easy to talk to", and, "I enjoy working here that is why I have stayed so long, we are a good team and everyone ticks along nicely." When asked to describe the quality of the service one person told us, "What you find here today was here yesterday and is going to be just as good tomorrow. They have made a lot of improvements to the environment for the last six months, look at the conservatory, look at the garden, look at the staff, who would not like to be here."

People, relatives and staff said they felt comfortable to air their views and, provide honest feedback to the registered manager and this was evidenced from our observations. When asked what people would like to see improve the quality of care they received, they told us, "I suppose if anything we could do with more entertainment, but how could you improve on perfection."

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service and on their public website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider did not display their rating and provide access to the most recent inspection report for people who used the service and their

visitors to view. We discussed this with the registered manager who told us they would ensure this was provided and confirmed shortly after our visit this had been rectified.

Systems were in place to receive people's feedback about the service. The registered provider sought the views of people, their relatives and staff. Views were gathered through the use of annual satisfaction surveys and meetings. This enabled people who used the service and staff to air their views and contribute to improving the quality of care provided. Feedback from people and their relatives included, "I cannot praise staff enough we are so lucky to have found this place." And, "Every member of staff is kind and cheerful and always ready to reassure me about any worries I might have." Responses from surveys had been analysed but further work was needed to evidence planning and actions taken in response to suggestions people had made following surveys and in response to comments and suggestions made at meetings.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered provider did operate systems and processes to ensure all reasonable steps had been taken to mitigate the risk of harm to people who used the service.</p> <p>There were ineffective systems in place to ensure the proper and safe management of people's medicines.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider did not ensure governance systems were in place and operated effectively.</p>