Mrs M J Tompkin

Orchard House

Inspection report

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Tel: 02392475038

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 16 January 2017.

Orchard House provides accommodation and care for up to 15 people who live with mental health conditions including dementia. The home is a large converted property and accommodation is provided over two floors. Two stair lifts were in place to assist people to move between the floors of the home. There were 15 people living at the home at the time of our inspection.

The home is run by the registered provider as an individual. They are the person registered with the Care Quality Commission to manage the service. A 'registered person' has the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst staff were aware of the risks associated with people's care and how to mitigate these, including those associated with some medicines, these were not always clearly documented.

Whilst incidents and accidents which occurred in the home were recorded there was no information on investigations completed following these incidents, any learning which came from these incidents or any patterns identified in these incidents. There was no information to show how this was shared with staff to prevent further recurrence in the home.

People received their medicines from staff that were appropriately trained; however some medicine administration records were not accurate.
People said they felt safe at the home. They were able to talk openly and honestly with staff and were sure any concerns or issues they had would be dealt with effectively. Staff knew people well and felt confident people would speak with them to raise any concerns. The registered provider and staff had a good awareness of how to safeguard people from abuse.

Whilst staff knew people very well and could identify how to meet each person's needs, care records did not always contain accurate and up to date information on people's needs.

There were sufficient staff to meet the needs of people. There was a very low turnover of staff and the stable staff group worked well together. With appropriate training and supervision processes in place, people were cared for by people who had the right skills and support to meet their needs.

Staff at the home had been guided by the principles of the Mental Capacity Act 2005 (MCA) when working with people who lacked capacity to make some decisions. The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered provider and staff had an understanding of the MCA and DoLS and when this needed to be implemented.

The atmosphere in the home was warm, calm and very friendly. Staff knew people well and demonstrated a high regard for each person as an individual.

People received nutritious and well-presented meals in line with their needs and preferences.

People had access to external health and social care professionals for support and treatment as was required. The home had good working relationships with other professionals including the local mental health team, community nurses, social workers and GPs. All health and social care professionals spoke very highly of staff in the service and the care they provided.

People had their needs assessed on admission to the home. The information gathered informed care plans which were discussed and agreed with people and their families. However care plans were not always kept up to date and did not always reflect the current needs of people and the care they received.

People had access to activities they requested and enjoyed. They were supported to maintain their independence through activities outside the home such as attending day centres and independent trips to the local shops and church.

The registered manager promoted an open and honest culture within the home where people were encouraged to voice their opinions and have these addressed. People and their relatives spoke highly of the registered provider and their staff.

The registered provider did not have a robust system of quality assurance in place to ensure the safety and welfare of people. There were no up to date audits on infection control, health and safety, medicines management or plans of care.

We found one repeat breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Care records did not always reflect the risks associated with people's care, including those associated with some medicines although staff had a good understanding of these.

People received their medicines from staff that were appropriately trained; however medicine administration records were not always accurate.

People were supported by staff who had a good understanding and awareness of abuse and how to ensure people were protected from harm.

There were sufficient staff working to meet the needs of people. Staff had undergone robust recruitment checks; the home had a low staff turnover and did not use agency staff

Is the service effective?

Good

The service was effective.

Where people could not consent to their care staff were guided by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported by sufficient staff who had the necessary skills and training to meet their needs. Staff knew people well and could demonstrate how to meet people's individual needs.

People received nutritious food in line with their needs and preferences.

People had access to health and social care professionals as they were needed.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was maintained and staff were

caring and considerate as they supported people.

People were valued and respected as individuals and were happy and content in the home.

People and their relatives were involved in the planning of their care although this was not always clearly documented.

Is the service responsive?

Requires Improvement

The service was not always responsive

Whilst staff knew people very well and understood how to provide appropriate care for them, care records were not always an accurate reflection of the care people needed or received.

Staff knew people well and respected their privacy and dignity. They cared for people in a kind and empathetic way, providing time and support in a relaxed and friendly manner.

People felt able to raise any concerns they may have about the home and they felt sure these would be dealt with promptly and effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records held were not always clear and accurate and did not always reflect the care people received or needed.

The programme of audit in the home to ensure the safety and welfare of people was not robust and had not identified the concerns we raised during our inspection.

The registered provider was visible in the home and they communicated effectively with people, their relatives and staff.

People were asked for their opinion of the service and feedback from relatives, staff and other professionals was good.

Orchard House

Detailed findings

Background to this inspection

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

One inspector completed this unannounced inspection on 17 January 2017. Before our inspection we reviewed the information we held about the home, including previous inspection reports and notifications of incidents the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with five people and two relatives to gain their views of the home. We observed care and support being delivered by staff in communal areas of the home. We spoke with one member of care staff, two senior care workers and the registered provider.

We looked at the care plans and associated records for five people. We reviewed the medicine administration records for 15 people and we looked at a range of records relating to the management of the service including; records of complaints, accidents and incidents, quality assurance documents, three staff recruitment file and policies and procedures.

Following our visit we received feedback from two groups of health and social care professionals who regularly visit the service and support people there.

Requires Improvement

Is the service safe?

Our findings

People felt safe in the home as staff knew them well and understood their needs. One person told us, "They [staff] are all lovely and really know me well. They keep me safe and understand when I am tired and need more help." People and their relatives felt able to speak to staff at any time and said any concerns would be listened to and acted upon. A relative said, "Oh yes, I know she [relative] is safe here so I do not have to worry about her." Healthcare and social care professionals spoke highly of how staff at the home worked to provide safe care for the people who lived at the home.

At our inspection in August 2015 we found the registered provider had not ensured medicines were stored and managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan on 11 September 2015 which identified the actions they would take to address our concerns although there was no completion date for these actions. At this inspection we found whilst the registered provider had installed a suitable storage system for controlled medicines, they had not taken sufficient action to ensure medicines were recorded accurately.

People received their medicines from senior staff who had received appropriate training and updates. Of 15 people, we found eight had prescriptions for medicines to be administered as required (PRN) and there was a lack of consistency in the recording of the administration of these medicines. There were no protocols in place although staff had recorded why some medicines had been administered and the effectiveness of these. For example, for two people who had been prescribed a medicine PRN to support them if they became agitated, there was no guidance in place as to when this should be given and how this was monitored for its effectiveness. Staff knew how and when this medicine was required to be administered but care records did not reflect this.

Risks associated with the administration of medicines had not always been identified. For example, one person was taking a medicine which thinned their blood. The risks associated with this medicine could include excessive bleeding following injury, illness due to blood clotting quickly and bruising. Whilst staff were aware of the risks associated with this medicine and how to monitor the person, care record did not always reflect these risks had been recorded.

For one person who was receiving a medicine to support them with agitation, the regular and PRN dose of this medicine which had been administered to the person was not in line with the prescribed dose on the medicines administration record or written on the medicine packaging. A senior carer told us the dose of this medicine had been amended by a health care professional. There was no information in care records, medicine administration records or communication records of this change to the dose of this medicine. We were not assured this person was receiving the correct dose of this medicine. Following our inspection we received assurances from the registered provider that the medicine had been administered correctly however the records had not been accurate at the time of our inspection. These had since been amended.

The lack of clear and accurate records in the management of medicines was a breach of Regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations.

Whilst medicines were stored safely and in line with legal requirements, we found some controlled medicines which had been prescribed for people who no longer lived at the home had not been disposed of in a timely manner. A senior carer told us these medicines would be disposed of at the next available opportunity with a pharmacist.

Whilst staff were aware of the risks associated with people's care needs, care plans did not always hold clear information to identify these risks. For example, for one person who was at risk of a break down in skin integrity they had an air mattress in place on their bed. Staff were aware this person was at risk of skin breakdown and the risks associated with the use of this equipment, however care records held no information on these risks.

Care records did not always reflect the risks associated with specific physical health conditions. For example, for two people who lived with diabetes staff could tell us how this was managed in the home and the risks associated with this condition such as poor circulation and high or low blood sugars, however there was no information in care records to identify these risks. Risk assessments were in place for some identified risks including falls and moving and handling concerns although these were not up to date. For one person whose mobility had declined following a serious incident and injury, daily care records noted their mobility was very poor and staff told us how they cared for this person and that a hoist was required to support them at times. Their care records held no information on how staff were should support this need and the risks associated with this.

Several people who lived at the home were able to mobilise independently in the community. For one person we saw risk assessments in relation to their ability to mobilise and ride a bicycle independently in the community were out of date and held information which had not been updated in line with their abilities. Whilst staff had a very good awareness of people's needs and abilities, care records had not always been updated to reflect these risks and ensure the safety and welfare of people.

The lack of clear and accurate records in place in respect of each service user and the care and treatment they required and received was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider held information for staff on how to recognise and report any safeguarding concerns or abuse. A copy of the local authority safeguarding policy was available in the home and all staff had received training in the safeguarding of people. No safeguarding concerns had been raised in the home since our last inspection; the provider explained what they would do should they receive any concerns in the service.

Individual plans to support people in the event of an evacuation from the home were in place. Staff were aware of contingency plans in place should they need to remove people from the home in the event of an emergency.

There were sufficient staff available to keep people safe and meet their needs. Staff knew people very well and interacted with them and encouraged them to remain independent in their daily activities. The home had a very low turnover of staff and this was reflected in the way in which staff worked well with people as individuals. The registered provider did not employ any external agency staff at the home.

The registered provider had not recruited any new staff since our last inspection. There were safe and

efficient systems in place for the recruitment of staff. Recruitment records included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services.

Good

Is the service effective?

Our findings

People lived in a friendly and homely environment where staff knew them very well and understood their needs. People were able to move around the home and community independently as they wished and staff supported them to remain independent and make choices in line with their needs and preferences. One person told us, "I do as I choose through the day, there are always people around to help and I am very happy here." Another said, "It's our home, we can do as we choose." Relatives spoke highly of the staff and the way in which they supported their loved ones. One said, "They always give [relative] the time to make up her mind, she is never rushed and seems very happy here."

The registered provider promoted a very supportive environment for all staff and as such the staffing group had remained consistent since our last inspection. Staff received support through supervision sessions, training and meetings where they discussed the care people received and the support and skills staff required to meet these needs. Staff felt supported through these sessions to deliver care in line with people's needs and preferences and to provide safe and effective care for people. They were encouraged to develop their skills through the use of external qualifications such as national vocational qualifications (NVQ). These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Two senior carer staff had recently completed NVQ level 5 in care management.

The staffing structure in place provided clear roles and responsibilities for staff. Senior staff provided a leadership role. They took charge of each daily shift and provided support and guidance for all staff. They fulfilled enhanced skills such as medicines administration and supporting external health and social care professionals on their visits. Staff said they felt very well supported by their peers, senior staff and the registered provider.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. The registered manager and staff had a good understanding of the processes required to ensure decisions were made in the best interests of people.

People were encouraged to make decisions at the home and appropriate measures were taken to support people who were unable to make some decisions. The registered provider worked closely with the local mental health team when assessing people's capacity to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst there were no people living at the home who were subject to these safeguards at the time of our inspection, the registered manager and senior staff understood when an application was required and how to complete this.

People received a wide variety of homemade meals and fresh fruit and vegetables were available every day. Care plans reflected people's food preferences, likes and dislikes and staff were aware of these and encouraged people to have a nutritious intake. The chef was aware of people's preferences and dietary needs; whilst only one set menu was available each day, the chef was able to provide alternative meals should people not wish to have this. People told us they enjoyed mealtimes as a social occasion and that the food was of a very high standard. One person told us, "The food is just great, really tasty and I can always have more if I want it." Another said, "We all get together at lunchtime and enjoy our lunch together." Mealtimes were a social occasion with friendly interactions between people and staff. The kitchen area was a clean and well managed area.

People had access to external health and social care professionals as they were required and care records reflected these visits. Health and social care professionals spoke very highly of the care and support provided for people there. They said staff provided very personalised and professional care for people and they always involved professional people in a timely and effective way to ensure the safety and welfare of people. Advice and guidance provided to staff was always followed and information was always readily available to any health and social care professional who was visiting to provide additional support.

The home consists of two converted older style buildings and whilst it remained a clean, warm and friendly environment for people there were some areas in need of redecoration. New floorings had been laid in most areas of the home although some carpets were due for replacement. Office and storage space for staff information and care records was very limited. Communal areas were clean although some were dated. We saw changes had been made to the décor of the home since our last inspection and the provider was taking steps to adapt, design and decorate the service and maintain an appropriate environment to provide care for people, whilst maintaining a homely environment.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. Staff understood people's needs and respected them as individuals. People enjoyed each other's company in a homely environment where they felt happy and comfortable. Many people had lived at the home for a number of years and this was reflected in the way they spoke of their "home" and the "family atmosphere" of the home. One person told us, "The staff are second to none. They are so caring." Another said, "We are really just like one big family and all get along together." Relatives told us how happy they were that their loved ones were in a home where they were so very well cared for. One relative told us, "You hear so many horror stories about the care of older people, but not here, they [staff] are all amazing and so very very caring." Health and social care professionals spoke highly of the home and the excellent relationship staff had with people and their relatives.

The atmosphere in the home was warm, calm and very friendly. Staff knew people well and demonstrated a high regard for each person as an individual. Throughout the day staff spent time chatting and laughing with people and they encouraged them to interact with each other. Staff interacted with people and each other in a calm and professional manner and took their time to ensure they responded to people in a way which was appropriate to their needs. For example, for one person who did not like to hear people say their name or whisper whilst they were nearby staff were clear in their communications with this person and ensured they were fully involved in any conversations. For another person who enjoyed banter with staff we saw they were encouraged to interact with staff and others whilst they moved around the home independently. For a third person who enjoyed their own company in their room and joined in activities as they chose, we saw staff encouraged them to remain independent and participate in activities of their choice. Staff were patient, calm and supportive as they moved around the home and encouraged people to remain independent whilst ensuring their safety and maintaining their dignity and independence.

People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. Doors remained closed when people were being supported with personal care or other activities and staff knocked and waited for a response before entering people's rooms. With a lack of office areas for confidential matters to be discussed staff were aware of the need to ensure conversations regarding people and their needs were held confidentially and with an awareness of where people might be overheard.

We saw people spoke with staff and the registered manager about things which were happening in the home and things they would like to do. People were able to express their views and be actively involved in making decisions about their care. They spoke with the registered provider or senior staff every day and did not feel they needed to have meetings regularly to express their views. Relatives told us they were always able to speak with the registered manager or any member of staff about the care their loved one received at the home.

Health and social care professionals spoke of the caring and kind support provided for people at the home, particularly for people who had very complex needs at times. They spoke of staff who were very dedicated to their work and knew the people at the home very well.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were encouraged to express their views and be involved in making decisions about their care. Whilst people were not always aware of the plans of care in place for them they told us staff knew them very well and they were always able to discuss their care needs with staff and have these addressed. People and their relatives felt staff understood how to support them to be as active and independent as possible whilst maintaining their safety and wellbeing. One person said, "I don't really know what is written down but I have discussed what staff do to help me, I do this all the time and the staff just help me with whatever I need." A relative told us they had been involved in planning care for their loved one when they entered the home, and that they spoke with staff during every visit to the home and felt their loved one received care in line with their needs and preferences. Health and social care professionals said staff knew people well, understood their needs and requested professional support appropriately to ensure people's safety and welfare.

People were assessed by a senior member of staff prior to their admission to the home and these assessments then helped to inform care plans. Health and social care professionals were involved in assessments of people prior to their admission to help identify their physical and mental health needs prior to admission to the service. People's preferences, their personal history and any specific mental or physical health needs or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs on admission to the home and how they wanted to be cared for. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care. They also noted people who were important to them and could assist them in making decisions.

Care plans were personalised and gave clear information about how people wanted to be cared for, the support staff should offer them and their daily routines. They gave examples of a "Good day" for people, and identified times when people may need additional support. However care plans were not always fully informed by the health needs of people or a change of need in their care.

Whilst care plans provided guidance for staff on how to meet the needs of people who lived with specific mental health conditions such as dementia, care records lacked personalised information on physical health conditions such as diabetes or a breathing condition. Whilst staff understood the needs associated with these conditions and how to support these people, care plans did not provide clear information on these needs. For example, for one person who lived with diabetes there were no care plans in place to reflect this condition and the risks associated with this. The community nursing team supported this person with the administration of medicines for this condition however there was no supporting information in care plans to reflect this or how staff should monitor or report any concerns to the community nursing team. Whilst people told us they spoke with staff regularly about their care needs, care plans and records were not updated or reviewed regularly. We saw care plans had not always been updated in line with people's changing needs. For example, for one person who had fallen and sustained a serious injury, incident and accident records showed they had been admitted to hospital for treatment and had returned to the home with increased needs to support their reduced mobility. This had not been reflected in their daily records or

care plans. Staff knew the person very well and were able to identify their needs and support them with these; however care plans had not been updated to show the changed needs of this person as a result of the injury.

The lack of accurate, complete and contemporaneous records in respect of each person's care and treatment was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no planned activities programme at the home, however people told us how they participated in activities such as singing, quizzes and music events. The registered provider told us they did not have a set weekly activities plan for people as the home prided itself in working with people and understanding their preferences to offer a wide range of different activities through the year. At the time of our visit people enjoyed a quiz and told us they were recovering from "Christmas celebrations" which had been fun. A hairdresser visited the home weekly and other activities for people, including music and art events would be booked into a diary. People told us they were very happy with the activities made available to them. They were also supported to leave the home independently and attend day centres, go shopping and attend church as they wished. People had a variety of areas they could use to interact with others and their relatives including their own rooms which were personalised and homely, the garden, a lounge area and dining area.

The provider's complaints policy was available for people to use but was not displayed in the home. People and their relatives received a copy of this when they were admitted to the home. The home had received no written complaints since our last inspection. The registered provider worked closely with people to enable concerns to be addressed promptly and effectively. Staff were encouraged to interact with people and their relatives, whilst maintaining their privacy, to ensure their needs were being met. Staff welcomed visitors in a warm and friendly way and encouraged them to express any views about the service their relatives received. Relatives told us they were able to speak with staff at any time but did not attend meetings at the home. People and their relatives said they felt able to express their views or concerns and knew that these would be dealt with effectively.

Health and social care professionals told us they were always warmly welcomed in the service and staff knew people very well. They said staff always requested support from other services appropriately to ensure they could meet people's needs.

Requires Improvement

Is the service well-led?

Our findings

People felt the registered provider worked hard to ensure they received good care and that they understood their needs. One told us, "The boss lady is very good; she knows her stuff and really looks after us all, and her staff, very well." Another said, "I know who the manager is and she is really good. All the staff are." People interacted with the registered provider and all the staff very positively and warmly and sought their support when they needed it. Staff promoted a very homely and friendly atmosphere in the home. Relatives told us the registered provider was very approachable and created a very welcoming and supporting environment for people. Health and social care professionals told us staff were always welcoming, had a very good understanding of people's needs and provided clear information for them when they visited. One professional told us the registered provider was, "extremely approachable manager, who is compassionate, caring and a good advocate for her residents".

Whilst feedback we received showed people felt the service was well led this was not a reflection of the findings at our inspection. The registered provider and staff did provide clear information and opportunities for people to share their views on the service and actively promoted a homely and friendly environment. However the registered provider had not taken sufficient steps to ensure they were complaint with all the regulations.

At our inspection in August 2015 we found the registered provider had not completed audits of care records to ensure care records were a clear and accurate reflection of people's needs and the care staff provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan on 11 September 2015 which identified the actions they would take to address our concerns although there was no completion date for these actions. At this inspection we found the registered provider had failed to address these concerns.

There were no systems in place to monitor, review and audit care records to ensure these were effectively maintained and demonstrated a clear and concise plan of care to meet the needs of people. Records were not always complete or up to date and some lacked order. We identified during our inspection that medicines records and care records were not an accurate reflection of people's needs and the risks associated with these. Whilst staff knew people very well and people received care in line with their needs and preferences, care records were not an accurate reflection of these needs and the care staff provided.

The lack of clear and accurate records which reflected the care and treatment provided for people was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not have an effective system of audits in the home to ensure the safety and welfare of people. Audits of medicines had not been completed regularly and had not identified the concerns we noted during this inspection which had been identified to the registered provider at our previous inspection. The registered provider had failed to audit risks associated with people's care and ensure these were reviewed and updated in a timely way. There was no clear programme of audit in the

home to review infection control risks or health and safety risks. Whilst the registered provider was able to tell us of maintenance tasks which required doing there was no clear action plan or time scale for these.

Incidents and accidents which occurred in the home were recorded and reviewed monthly by a member of staff. However, there was no information in these records to show the registered provider had reviewed these incidents and actioned any learning from these. Whilst daily care records and incident forms held information on any incidents and accidents which occurred, there was no information to show any actions taken to investigate these incidents address any patterns or trends in these events or learn from these. For example, one person displayed behaviours which may put themselves or others at risk of harm. Daily care records showed several events which had required staff intervention to support this need. We saw the registered provider had sought support from a health care professional to manage this situation, however care plans and records held no information as to how staff had identified the need to involve a health care professional or what other actions they had taken to identify any triggers or events which had led to these incidents.

For two incidents which had resulted in serious injury to people, accident records held no information as to any investigation which had been completed following these incidents. Whilst the registered provider and staff were able to tell us about the events, how these had occurred and the actions they had taken to ensure the safety and welfare of people, there was no information available in incident and accident reports to identify these actions or how any learning from these had been implemented.

There was a lack of clear systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. There were was a lack of systems and processes in place to assess, monitor and improve the quality and safety of the service provided at the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider told us they had notified the Commission by post of all incidents which they were legally required to do so, including two serious injuries and several deaths which had occurred in the home since our last inspection. The Commission had not received this information. Following our inspection the registered provider took steps to ensure all further information would be sent to the Commission electronically to ensure this was received in a timely manner.

The registered provider was present in the home most days and met with staff, people who lived at the home and their relatives or visitors each day. They provided clear information on any updates or changes in the home although no formal notes were made of these discussions. People and their relatives spoke highly of the registered provider and their team of staff and told us they were all very approachable and promoted open and honest communications in the home. Surveys were given to people and their relatives annually and the feedback from these was positive. The registered provider told us how they responded to any areas which needed improvement such as a change in a menu or the need for resources for activities.

The home had a clear leadership structure which allowed people to feel valued, involved in the running of the home and an integral part of an efficient team. The low turnover of staff in the home meant staff knew each other very well and worked efficiently as a team to meet the needs of people whom they knew very well.

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 registered provide had failed to maintain complete and contemporaneous records in respect of each person in the service and the care and treatment they required and received. There was a lack of clear systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. There were was a lack of systems and processes in place to assess, monitor and improve the quality and safety of the service provided at the home.