Aston Care Limited

Hill View

Inspection report

33 Church Walk South
Swindon
Wiltshire
SN2 2JE

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05 June 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Hill View on 31 May 2017. This was an unannounced inspection. We returned to complete the inspection on 5 June 2017.

Hill View is a care home without nursing that provides personal care and support for up to eight people with learning disabilities. At the time of the inspection there were five people living at the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission(CQC) 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. A new manager had joined Hill View at the beginning of May 2017. The new manager intended to apply to the CQC to become the registered manager of Hill View.

We asked for feedback from people's relatives and they felt the service was safe. However, we found training which the provider had stated was mandatory, had not always taken place to ensure staff were fully competent to support people safely. This included training around medicines, moving and handling and safeguarding. The provider had safeguarding training planned for staff for the end of the month. The provider had policies and procedures in place in relation to safeguarding adults.

People's care records contained risk assessments. These identified any risks related to each person and described the measures and interventions to be taken to manage risks. However, the risk assessments needed more guidance to ensure that staff could ensure people's safety.

Staff had not undergone all necessary training to ensure they were able to meet the support needs of people in the service. Staff told us and we saw they had received regular supervisions with the manager, where they had the opportunity to discuss their care practice and identify further training needs.

Relatives said they were satisfied that their relatives were involved in all day to day decisions about their care. However, not all staff had received training about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were supported in line with the principles of MCA and DoLS. Staff need to have an awareness of these principles to ensure that people are supported to have maximum choice and control of their lives and in the least restrictive way possible. We made a recommendation to consult with the current guidance for the DoLS.

There were sufficient numbers of staff to support people safely. Staff had been checked before they started working for the service to ensure they were suitable to work with vulnerable adults.

Medicines were managed in a safe way and the environment had been assessed to ensure its safety.

People were supported to have the food they enjoyed and to maintain a healthy diet. Care records showed people's health was monitored and referrals were made to other health care professionals where necessary for example, GP and mental health team.

Relatives spoke highly of the caring attitude and behaviour of the care staff in the service. They said their relatives were treated with dignity and respect by staff.

People had been assessed to see what support they required before moving to the service. However, not all information on the assessment had been incorporated into the care plan. People's care plans did not always reflect people's current needs, choices and preferences.

People were encouraged to plan and participate in activities that were personalised and meaningful to them. We saw evidence of people being supported to be involved in their local community.

We saw a complaints procedure was in place and this provided information on the action to take if someone wished to make a complaint and what they should expect to happen next.

The registered manager had not always notified the CQC about incidents that affected the service.

We found the provider had not taken all the necessary actions to ensure effective quality assurance systems. There were no audits in place to effectively identify and review areas of improvement.

Relatives and staff were confident that the new manager would take the steps to make the necessary improvements to the service.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified one breach of the Care Quality Commission (Registration) Regulations 2009.

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.

People were not protected fully from avoidable harm as staff had not received all mandatory training to ensure people were kept safe.

People's risks had been assessed but these were not always updated in their records.

Medicines were administered safely.

Staff had undergone safe recruitment procedures and there were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received the appropriate training to ensure they had the skills and knowledge to meet people's needs, preferences and lifestyle choices.

Staff showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, training had not been undertaken by all staff.

Staff felt supported by management and records were in place to evidence they had received one to one meetings.

Healthy eating was encouraged and people were given choice and options. .

People were supported to ensure their health needs were met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and their dignity was respected.

Relatives spoke positively about staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's support plans did not always reflect people's care needs.

People had access to activities and social events to protect them from social isolation.

Relative's felt any complaints or concerns raised would be dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

Statutory notifications had not been made to the Care Quality Commission as required.

There were no quality assurance systems in place to continually review the service including, audits on care plans, safeguarding concerns and accidents and incidents,

Hill View

Detailed findings

Background to this inspection

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

This inspection took place on 31 May and 5 June 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. We requested and received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service

We observed how staff interacted with people who used the service and monitored how staff supported people during the day to help us understand the experience of people who could not talk to us. We also spoke with two relatives. We spoke with registered manager, the manager and six care staff.

We looked at three people's care records including their medicines records. We also looked at documentation relating to the management and running of the service including policies, records of accidents and incidents. We also looked at staff rotas, three staff files, supervision records, recruitment procedures, training records and team meeting minutes.

We looked at how the service implemented the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

Requires Improvement

Is the service safe?

Our findings

People had plans in place detailing the support required to manage any assessed risks. The files we viewed contained risk assessments for people with epilepsy, moving and handling and diabetes. One person's record identified they were at risk of epilepsy and contained information about how to reduce the risk. However, the guidance would have benefitted from being more specific. For example, it stated the person was to be observed regularly or frequently but did not state how often this should be. This meant staff may be unclear about how often the person should be checked which could increase the risk of harm.

Care plans did not contain clear guidance to staff on how to safely support people with equipment and reduce risks. For example, where hoists were used, there was no information to staff on how to individually support the person with this equipment safely.

A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who may require support to leave the premises in the event of an emergency. However, this did not detail where people were located in the building. This meant in the event of emergency assistance there could be a delay in ensuring everyone was evacuated safely. The manager said they would amend the plans with details of where people were in the building.

Where people had charts in place to monitor weights, food and fluid these were not consistently completed or analysed. For example, one person needed to have their intake and output of fluid recorded. We saw some evidence of output in the person's daily records but this information had not been analysed to see if the recordings were accurate. This meant effective monitoring to see if any action was necessary was not taking place. We also saw that a person's bowel movements were monitored as they were at risk of constipation. We noted that this person had not had a bowel movement for four days 16 May to 20 May 2017. No action had been taken, for example, to ensure the recommended amount of fluid had been maintained or if medical attention was needed. Therefore, the risks had not been monitored to reduce the risks relating to their health.

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

The manager was aware of the local authority reporting process in relation to safeguarding concerns and it was displayed on the staff noticeboard for guidance. Staff understood their responsibilities to report any concerns to the manager. One member of staff told us, "I would tell the manager if I had concerns." The service had policies and procedures in place for safeguarding adults and these were accessible to members of staff.

Medicines were in blister packs and were clearly labelled and stored separately to ensure people received their correct medication. Staff were assisted by a patient information chart which had photographs of the medication and clear directions about when each tablet should be taken. There was a MAR (medicine administration record) in place for all service users which reflected the persons' current medicines and had

been fully completed. We saw that medicines were stored securely in locked trolleys and kept at an appropriate temperature. We checked the balances of medicines not in the blister packs which were correct. Staff documented a reason if a person did not take their medicine. There was a system in place to manage the ordering and disposal of medicines.

Some people had been prescribed medicines to be administered on an 'as required' or occasional basis (PRN). The provider maintained records of when these medicines were administered and the reasons for their administration. This ensured people's behaviours were not controlled by excessive or inappropriate use of medicines. We saw guidance for staff about homely medicines.

Where people displayed behaviour which could put themselves or others at risk, training had been arranged to assist staff to manage this positively and to protect people's rights and dignity. This meant that physical interventions would only be used as a last resort after attempts to prevent or manage the situation had not worked. The training would help staff to understand that behaviour which challenges was a form of communication and to understand the triggers and signs that may alert them. One member of staff told us that a person who had recently moved to the service was no longer exhibiting a particular behaviour now they had settled in.

There were two people who required full assistance with transfers via a hoist. The moving and handling policy stated that training would be provided before staff were allowed to use the equipment and carry out these procedures. At the time of this inspection, seven staff had not received this training. Therefore, this meant ensuring only trained staff were on each shift to undertake these manoeuvres reduced the number of staff able to be on the rota. There was a risk that this could impact on the person's care if a staff member was absent at short notice.

At the time of the inspection, there were five people supported by the service and three placement vacancies. The needs of the people were being met with the current staffing levels. Staffing levels were determined by the person's needs and this was considered when new placements were being explored. The registered manager said two waking night staff were in place overnight to ensure the high needs of people in the service were supported. Due to the recruitment of permanent staff, it was anticipated that agency staff would not be needed on a frequent basis. Where agency staff were used, the service tried to ensure they only used agency staff who had worked with the service before. An on-call system was also being introduced so that staff received support if needed.

We spoke with a relative and asked them if they felt the service was safe. They replied, "Until the new manager arrived we were actually thinking of moving [name] because of [risks from another person]. As a family we are more than happy with the home now and realise they put safety first."

The provider operated a safe and effective recruitment system. Records confirmed that the necessary recruitment checks had taken place before staff were employed to work at the service. Staff files contained a written application, two references from previous employers, proof of identity and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helped employers make safer recruitment decisions and prevented unsuitable people from working with vulnerable adults.

Environmental risks to people were assessed and monitored. Fire and general premises risk assessments had been carried out. We saw documentation and certificates which showed that relevant checks had been carried out on water temperatures, gas appliances and the lift.

Requires Improvement

Is the service effective?

Our findings

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR stated that all mandatory training was delivered to staff, including safeguarding, moving and handling and medicines. However, five members of staff who had been in the service for more than 12 weeks had not received this training at the time of the inspection. Safeguarding training had been arranged for the end of June and end of July.

The medicine policy stated that only staff who had been trained could administer medicines. Not all staff had received training on the safe handling of medicines and administration of medication. We saw on the training matrix that only six members of staff had received this training. We also saw no evidence that any of the staff had their competency checked to ensure they were administering medicines safely. Training was planned for the end of June for all staff on a new medication system being introduced in the service.

New staff were issued with an induction workbook which they completed and discussed with the manager to review. The policy stated that new staff shadowed more experienced staff and were not allowed to support people alone until all mandatory training had been undertaken. However, we saw some staff, who had worked for the service for over twelve weeks, had not received training to enable them to meet people's specific needs. For example, only six staff had undergone training for epilepsy awareness, diabetes and moving and handling.

Other training such as food hygiene, Mental Capacity Act and Deprivation of Liberty Safeguards, and person centred approaches had not been received by all staff. Due to the relatively new staff team in place it was not certain that staff had received the training required to ensure they could support people's needs. We spoke with a member of the care staff who confirmed they had received training but they had worked for the provider for some time.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were well supported to carry out their roles. We saw records were kept of when staff had met with their line manager for supervision. Staff we spoke with confirmed they received regular supervision.

Not all staff had completed training on the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. However, staff demonstrated knowledge of the principles of the MCA. One member of staff told us, "I always provide choice and understand someone can say no. If this involved medicines I would wait for a while and try again. If the person was still resistant

we would need to make a best interest decision."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The registered manager and manager had submitted relevant applications to the relevant local authorities. However, there were no guidelines in place about ensuring the least restrictive option was used whilst awaiting authorisation.

We recommend that the service consults with current guidance in respect of DoLS best practice.

Staff understood the need to assume capacity. For example, a staff member said, "[Name] doesn't have capacity in many areas but can certainly choose what to wear, when to go out and what activities she wants to do."

People had choice and enjoyed the food provided. A relative told us, "Food always looks and smells lovely." We observed the lunch period and saw three people having one to one assistance with their meals. This was done in a dignified and respectful manner and was not rushed. We asked care staff how they knew what people liked to eat or drink. One staff member said, "Information from their care plan and from the person's previous placements." A member of care staff said the service was in the process of developing picture cards of food and dinners to help people decide what they would like.

Food shopping was done online by care staff who also did the cooking. This was done by checking people's dietary needs and likes from care plans. The care staff said they deliberately left off two or three items from the list so that people could go for a trip to the shops every few days. The kitchen was clean, tidy and organised, with appropriate hygiene signage and a raw meat preparation area. There was a menu list. Plans were in place to employ a cook for the service to release the care staff of this responsibility.

Relevant professionals had been involved where needed. For example, a referral had been made to a speech and language therapist regarding a person's swallowing difficulties. We saw advice about ensuring the person ate slowly and swallowed each mouthful to reduce the risk of choking. We saw a person with diabetes had a risk assessment in place and advice about low sugar diet. We observed people being supported appropriately during their meals.

People were supported by staff who knew their routine health needs. People were assisted to have access to relevant healthcare professionals, such as GP's and dentists. People had health action plans in place. Referrals had been made where necessary to health and social care services. We saw updates following consultations from specialists about the health needs of people in the service.

Good

Is the service caring?

Our findings

We observed and received positive feedback about the caring attitude of staff. Staff were attentive and individually caring for people on a one to one basis. A relative said, "The staff there are brilliant; caring, compassionate, always kind thoughtful and will go out of their way to support [people]. It is the first time in 10 years my [relative] has been in Swindon for his birthday. They woke him up singing Happy Birthday, decorated the lounge/dining area in banners and balloons. They must have spent hours cooking for the nine people from his family that attended. It was a lovely day and very grateful for what they did."

We heard from another relative who said, "The staff both previously and current show a very caring attitude to [name]. They show their fondness for her and are actively involved with us to make sure she gets the very best of everything. They help us as a family to ensure that they keep in touch if there are any issues with her behaviours and also help choose new clothes and so forth. They are very proactive. They also want to be involved in any meetings we have with regards to her care and her future. We are very grateful that we feel that they will always do their best for her."

People were supported by caring staff that were enthusiastic. Staff told us they enjoyed working at the service. One member of staff said, "When a person first came here, they could not talk. After one week and a day they started talking. His parents were emotional when they heard him talking on the phone." We asked the member of staff what they thought had made the person speak and they said, "I think he felt safe here".

Relationships between people and care staff demonstrated dignity and respect at all times. Staff knew, understood and responded to each person's needs in a caring and compassionate way. A relative said, "The staff always treat him with dignity and respect, ensuring if he is incontinent he is taken to his bedroom to be assisted to change in a quiet and dignified manner." Another relative commented, "The staff knock on her door before entering her room. They close the curtains and door when doing any care and also to ensure they hear her if she has a seizure, there is a monitor in her room. When she is showered and washed, only female staff are allowed to carry this out."

People were supported to express their views and staff were skilled at giving information and explanations needed to make decisions. A relative told us, "[Name] did not want to eat a certain lunch and they tried him with two other dishes until he ate his lunch." Another member of staff said a person's communication had recently improved and they had discovered they were good at writing and numbers. They encouraged the person to engage with this and one commented, "I was so proud he could spell."

Relevant information from people's histories had been added to their care records. For example, we saw information recorded about what a person used to enjoy when they lived at home, such as helping to decorate at Christmas and their routines on Christmas day. There was a list of family birthdays so they could be assisted to remember these and send cards. This information was helpful in staff understanding things that were important to individuals.

During the day we saw staff asking people if they were alright and if they needed anything. This created a

kind and caring environment. We saw a member of staff asking a person if they liked their food or if they wanted more.

Where people were nearing the end of their life they received compassionate and supportive care. One person had an end of life care plan with their wishes to ensure they were supported to be comfortable and well cared for without unnecessary medical interventions. A palliative care specialist was also involved.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed prior to receiving support. One relative said they had been involved in providing information for their relative. Another said, "We are always consulted about everything and also updated when any one comes to see [name] or when they attend for doctor's appointments and blood tests and so forth." This ensured the views of the person were known, respected and acted upon if they were unable to verbally contribute to their care planning.

However, not all information on the assessment had been incorporated into the care plan. For example, there was information on a person's assessment about what they liked, but this was not in the care plan which the staff referred to. We spoke to the manager about this, who said they planned to review all the care plans to gain information from family members and staff to ensure they contained all the information that was important.

People's care plans did not always reflect people's current needs, choices and preferences. We found that people's changing care needs were not always updated in care plans. It was not clear whether these changes had therefore been communicated to staff looking after them. For example, we saw that a person needed hoisting to the toilet, but we found out this was no longer happening due to the person deteriorating. This meant people may be at risk of inconsistent care or not receiving the care and support they need.

Care plans did not contain all relevant information. More thorough guidance would have assisted in aiding communication with people that were non-verbal. For example, a person's care plan said the person could communicate via facial expressions but did not explain what these expressions were and what they meant, for example, in pain or unwell. This was important as we had feedback from a relative about asking a GP to put pain relief as a standard daily medication instead of 'as needed'. This was because they were not confident that staff would always know the signs of distress.

Another care plan stated a person may get tearful but did not say why this might be and what to do if it did happen. We also saw information on a person who had diabetes who needed to be monitored for signs of either high or low blood sugar. There was no information for staff on what signs or symptoms may need to be acted upon.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained information on emergency contacts, specialist equipment, medicines, appointments and emergency information to go with people in the event of hospital admission. There was information on people's care needs such as what support was needed for personal care, needing to visit the dentist yearly and how to communicate such as using humour and plenty of encouragement. Also it stated to use the person's name at the start of the conversation, not to speak quickly and to maintain eye contact. Some care plans contained detailed information on people's likes and preferences such as liking music and music

videos, and enjoying family and friends visiting and going for meal with them. It also stated what they didn't like such as loud noises and being rushed.

People were protected from social isolation because social contact and companionship had been considered. People were offered person centred activities and encouraged to maintain relationships that mattered to them such as family, community and other links. Staff told us that people were visited regularly by their families and were welcome at any time. A member of staff said, "The families are very involved and we encourage this." Another said, "They all have family and they can come anytime." A relative told us, "I feel I can come here anytime and I visit every day."

During the inspection we saw that people were involved in activities with members of staff. This was mostly taking place in the conservatory at the back of the house which was light and airy. It contained lots of activity equipment such as crayons, pencils, jigsaws and games. We saw a person doing a jigsaw with a member of staff and another was playing a keyboard. Directly after lunch a person went out for a walk with two members of staff. Another person was having their nails painted. When asked if they enjoyed what they were doing they all smiled.

There was a board on the wall with activities listed such as skating, baking, a beauty day, arts and craft, karaoke, church and sensory room. We saw that other activities that had taken place included, day trips, cinema trips, meals out and a men's night.

Relatives were confident about the management dealing with concerns. One commented, "Regrettably as the home is new, there have been a few teething problems when staff have come and gone and where, at times, we were a bit worried about staffing levels. Also we really didn't want male carers carrying out personal care. It has taken some time for the staff to adjust to [name] very rapid descent in to dementia. We had lots of meetings with everyone connected to Hillview and with the doctor, hospice nurse and the dementia nurse. We have put in place everything we all need for the future and to facilitate her end of life with all medication and agreement all round."

There was a notice about raising complaints at the entrance of the home. There was a policy on raising concerns or making a complaint. We saw that this policy had not always been followed. For example, a relative had written to say that her relation (who did not have capacity to agree) had been moved to a single room. It was acknowledged that it would have been courteous to consult with the person's relative to consider their views. A relative told us, "I'm not sure if Aston Care has a complaints procedure. I previously raised a concern and was not happy with the response. However, I am happy that [manager] will listen to any concerns and seems a good manager. So I am hopeful that [manager] can do an amazing job in Hill View."

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection, the service had a registered manager who was not always on site because they managed other services. However, the service had employed a manager to work permanently at the Hill View service from the beginning of May 2017. The manager intended to apply to the CQC to become the registered manager for Hill View in due course. During this time the manager was in close contact with the registered manager and the directors and was committed to improving the service.

The registered manager had not extended the quality assurance systems to ensure that they met all of the requirements in relation to the regulated activities. There was no process to ensure that quality and safety were being monitored and action taken where necessary. For example, there was a policy entitled Quality Assurance and Management System which stated that periodic reviews or audits should take place. We found these had not taken place. For example, we saw no audits of care plans which would have highlighted that not all were up to date. Incidents and accidents had not been reviewed or audited to ensure any action was taken to minimise these occurring again. An audit may have identified any trends in these records that may need action taken. For example, incidents between two individuals resulting in harm.

The policies had all been reviewed in March 2017. However, we noted some policies did not have the correct information on them. For example, the whistleblowing policy needed more information about contact numbers and procedures to follow.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records about accidents and incidents. These showed that the service had not sent notifications of incidents and events to the CQC which were notifiable under current legislation. Statutory notifications help CQC to be updated and monitor key elements of the service. For example, there had been a break in at the service and the provider had not notified the CQC. We explained to the manager that this meant they were not meeting the requirements of their registration. They said they would take immediate action to ensure reporting of necessary incidents were completed and submitted as per the requirements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People's views and those of their relatives and other stakeholders had not been sought by the service at the time of the inspection. These would have provided feedback about the quality of the service and any suggestions for changes. The manager told us there were plans to seek this feedback in the near future.

The service held monthly team meetings. We saw records that these had taken place and issues such as upcoming training were discussed. Staff we spoke with confirmed they had regular team meetings and said they were beneficial to discuss things together.

Staff we spoke with told us the new manager was approachable and they felt supported in their role. The

atmosphere during the inspection was calm and light-hearted. One staff member told us, "I feel he's very proactive and communication is good." Another staff member told us, "I feel I can go to him if I have a problem and also if I have any ideas to share." Staff enjoyed their roles with one commenting, "You have to be into it or a certain type of person and I just like helping people." An on call system was being arranged to support staff out of hours where advice and guidance may be required. A relative told us they were very confident in the new manager and said, "They have a beautiful home, people and brilliant staff. Now they need someone who can support and guide them all. The recent improvement is [name] seems a good manager. Until a month ago it was not managed well." Another relative said, "I think that since a new manager has been appointed, the home is run very well. I am happy with [name] care."

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not sent notifications of incidents and events to the CQC which were notifiable under current legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessment's did not always contain enough guidance to keep people safe. Risks had not been monitored to ensure action was taken where needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that effective systems or processes were established and operated effectively to assess, monitor and improve the quality of the service. Not all risks had been identified so they could be reduced and monitored. Care plans did not contain all relevant information.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff had received the appropriate training to support people's needs.