

Moreland House Care Home Limited

Moreland House Care Home

Inspection report

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Date of inspection visit:
07 September 2016
08 September 2016

Date of publication:
07 November 2016

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?

Good 

Summary of findings

Overall summary

This unannounced inspection took place on 7 and 8 September 2016.

Moreland House is a purpose built 50 bed care home providing accommodation and nursing care for older people, including people living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. When we visited 47 people were using the service.

The service did not have 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 and associated Regulations about how the service is run. The current manager was in the process of registering with CQC.

At the last inspection on 23 and 24 September 2015 we asked the provider to take action to make improvements with regard to medicines storage and recording, taking action when possible abuse had occurred and dealing with emergencies. The provider sent us an action plan detailing the action they were taking to meet these requirements. At this inspection we found that the actions had been completed.

The arrangements for administering medicines were not always safe. People who received their medicines without their knowledge (covertly) were not managed safely. However, the issues found at the previous inspection had now been addressed.

Systems were in place to safeguard people from abuse and staff were aware of how to identify and report any concerns about people's safety and welfare.

Staff received the training and support they needed to carry out their duties and to provide people with the support they needed and wanted.

People were supported to receive the healthcare that they needed. They told us they felt safe at Moreland House and were supported by kind and caring staff.

We saw that staff supported people patiently, with care and encouraged them to do things for themselves. Staff provided care in a respectful way that promoted people's dignity.

The provider's recruitment process ensured staff were suitable to work with people who need support.

Systems were in place to ensure that equipment was safe to use and fit for purpose. People lived in a clean, safe environment that was suitable for their needs. We have recommended that the floor cleaning system be reviewed to ensure that people are not placed at risk of falls due to wet floors. We have also recommended

that further consideration be given to make the internal environment more dementia friendly.

Complaints were taken seriously and concerns addressed but some people were not aware of how to complain or whom to complain to. We have recommended that action be taken to remedy this.

Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People told us that the food was good and that they could have a drink when they wanted. People's nutritional needs were met and if there were concerns about their eating, drinking or weight, this was discussed with the GP and support and advice were sought from the relevant healthcare professional. For example, a dietitian.

We have recommended that lunchtime arrangements and support be reviewed to ensure that people have a more pleasurable meal time experience at a pace that suits them.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

An activities worker was employed and social and recreational activities and events were available. People told us that they particularly enjoyed the exercise activity.

People's care plans were being reviewed and updated to ensure that they were clear and sufficiently detailed to enable staff to support them safely and effectively.

The provider had systems in place to monitor the service provided and people were asked for their feedback about the quality of service provided.

We found one 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?

Not all aspects of the care provided were safe. The system for administering medicines was not robust.

Risks were identified and systems put in place to minimise risk in order to ensure that people were supported as safely as possible.

Staff were trained to identify and report any concerns about abuse and neglect felt able to do this.

There were sufficient staff on duty to meet people's needs.

The provider's recruitment process ensured that staff were suitable to work with people who need support.

The premises and equipment were well maintained to ensure that they were safe and ready for use when needed.

Requires Improvement 

Is the service effective?

The service was not consistently effective. Although people told us that they were happy with the food and drink provided the lunchtime experience was not always positive.

Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff team had the training they needed to ensure that they supported people safely and competently.

People's healthcare needs were identified and monitored and referrals made to other healthcare professionals when needed.

The environment had been designed to support people living with dementia but further work was needed to make the internal decorations and signage more dementia friendly.

Requires Improvement 

Is the service caring?

The service was caring. People were treated with kindness and

Good 

their privacy and dignity were respected.

Staff supported people in a kind and gentle manner and responded to them in a friendly and patient way.

Staff provided caring support to people at the end of their life.

Is the service responsive?

Not all aspects of the care provided were responsive. Care plans did not always give sufficient detail to ensure that people received care and support that fully met their current needs. However, these were being reviewed and updated.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Activities, entertainment and trips out were available and an activity worker was in post to support this.

Complaints were taken on board and action taken but some people did not know how to complain or whom to complain to.

Requires Improvement ●

Is the service well-led?

The service was well-led. People were positive about the changes the manager had made since they came into post.

Staff told us that the manager was accessible and approachable and that they felt well supported.

People were consulted about changes to the service and the provider sought their feedback on the quality of service provided. Their comments were listened to and addressed.

Systems were in place to monitor the quality of service provided. Actions identified during monitoring visits were clearly recorded and followed up at the next visit.

Good ●

Moreland House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 unannounced inspection took place on 8 and 9 September 2016.

The inspection team consisted of one inspector, a specialist nurse advisor 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 service.

Prior to the inspection, the provider 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." Before our inspection, we also reviewed the information we held about the service. We contacted the commissioners of the service to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with nine people who used the service, the manager, the provider, three nurses, two senior care staff, four care staff, the chef, nine relatives and the area manager. We looked at nine people's care records and other records relating to the management of the service. This included three staff recruitment records, duty rosters, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Is the service safe?

Our findings

People told us that Moreland House was a safe place to be. One person said, "I feel safe here, just as I was before." Relatives also felt that people were safe. One commented, "[My parent] is safe here and they always inform me about their care." Another told us that there had been concerns earlier this year but they no longer fearful for their relative's safety. They said, "I now feel [my parent] is safe and we feel we're being told the truth."

At the last inspection in September 2015 we found that the systems in place to ensure people received their prescribed medicines safely and appropriately and the systems in place to deal with emergencies were not robust. Also appropriate action had not always been taken when possible abuse had occurred. During this inspection we found improvements had been made but further work was needed to ensure that people received their prescribed medicines safely.

People who received their medicines without their knowing (covertly) or who had their medicines crushed were not appropriately managed. For covert medicines meetings had not taken place between care home staff, the health professional prescribing the medicine(s), the pharmacist and a family member to agree that administering medicines covertly was in the person's best interest. For crushed medicines the pharmacist had signed that some medicines could be crushed but there was not any confirmation that the person had the capacity to make an informed decision about receiving their medicines in this manner. Additionally there were not protocols to follow to ensure this was done safely and that staff ensured the person knew they were getting their medicines each time so they had the option to refuse. There was no evidence or record that other options, such as liquid alternatives had not been explored.

Individual guidelines were in place for the administration of 'when required' (PRN) medicines. However, these were not always sufficiently detailed or clear enough and did not contain all of the necessary information to ensure people received these medicines appropriately and effectively. For example, the route and frequency of administration, minimum time interval between doses, why medicine given and the expected outcome and details of the person's capacity to refuse the medicines. Also there was not any information on how the needs of the person should be identified. For example, how signs of pain were expressed in a non-verbal way.

The issues highlighted above evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw medicines were safely and securely stored in appropriate locked medicines trolleys in the nurse stations. The person responsible for the administration of medicines kept the keys with them during their shift. When not in use medicines trolleys were secured to the wall. Controlled drugs (CD) were stored safely and securely in an appropriate CD cupboard. Medicines requiring cold storage were kept within a locked fridge in the treatment room. Minimum and maximum temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were kept at safe temperatures to remain effective.

Staff who administered medicines had received medicines training and been assessed as competent to do this. Medicines training and competency assessments took place before staff began to administer medicines and then yearly. Appropriate arrangements were in place in relation to the recording of medicines. Medication Administration Record (MAR) charts were properly completed and were easy to follow. They included people's photographs to check that medicines were given to the correct person. Allergies were also indicated. In line with good practice opening dates were recorded on liquid medicines, drops and creams to ensure that they were not used after the expiry once opened period.

The provider had systems in place in the event of an emergency. There was a fire risk assessment and fire evacuation procedure and these were reviewed annually. There was also an emergency evacuation plan in place which included detailed of places of safety that people could be taken to and transport information. Approximately 30 staff had received first aid and basic resuscitation training this year and training for the remainder had been arranged for two dates in October 2016. Instructions on what to do if a person was choking were displayed. One person told us that they had a condition that could cause them great distress. Information about their condition and what needed to be done were displayed in their room. The person told us that felt secure that staff knew what to do.

Systems were in place to safeguard people from abuse. Staff were aware of different types of abuse and knew what to do if they suspected or saw any signs of abuse or neglect. They told us that they had received safeguarding adults training and that they felt confident to report bad practice. One member of staff said, "I know my residents, and I would have no problem whistleblowing if I saw something wrong. Their care comes first." The service held monies for some people to pay for hairdressing, chiropody and other small items. We saw that monies were securely stored in individual envelopes and that access was restricted. We checked the monies and records for three people and found that the amount of cash held tallied with the record. The provider had notified us about safeguarding incidents and had worked with the local authority and taken action to make sure people living at the service were protected from risk of harm or abuse.

We found that risks were identified and systems put in place to minimise risk and to ensure that people were supported as safely as possible. People's files contained risk assessments relevant to their individual needs and gave guidance to staff on how to maximise safety. For example, issues relating to behaviour that challenges.

The premises and equipment were appropriately maintained. Records showed that equipment was available, serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. One person told us, "I have all the equipment I need here." Staff reported there was adequate equipment to meet people's needs.

Gas, electric and water services were maintained and checked to ensure that they were functioning appropriately and were safe to use. Records also confirmed that appropriate checks were carried out on hoists, pressure relieving mattresses and fire alarms to ensure that they were safe to use and in good working order. A fire risk assessment was in place and staff were aware of the evacuation process and the procedure to follow in an emergency.

People were protected by the recruitment process which ensured that staff were suitable to work with people who needed support. This included prospective staff completing an application form and attending an interview. We looked at three staff files and found that the necessary checks had been carried out before staff began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with people who need support. Nurse's registration with the Nursing and Midwifery Council was also checked to

ensure that they were allowed to practise in the United Kingdom. There was evidence in staff records to confirm that they were legally entitled to work in the United Kingdom.

There was a mixed response from people regarding staffing levels. Some felt that there were not enough staff and their comments included, "Sometimes they haven't got a lot of time to talk but they do when they can" and "They look after me very well. Maybe they could have a few more staff, though." However, others felt that there were enough staff and that they did not wait very long to get support when needed. For example, one person said, "The carers are nice. They come quickly, especially if you are not well." We also received a mixed response from staff, with some stating that staffing levels were satisfactory and others saying that on occasions the staffing numbers on duty struggled to get through the demands of the day. During our inspection we found that there were sufficient staff on duty to meet people's needs and that staffing levels had been reviewed and changes made when needed. For example, there were now three nurses on duty during the daytime shift instead of two. In addition agency staff were rarely used with shifts covered by bank or permanent staff and therefore a more consistent service was provided.

We saw that all areas were clean and that people were cared for in a clean and hygienic environment. However, in the morning we found that corridor floors were very wet as a result of mopping and were very slippery. People needed to access the corridor to move around the building. For example, to reach the toilets, their rooms or to go for breakfast. Warning signs were in place but some people living with dementia would not have understood the risk. The manager ensured that immediate action was taken once this issue was raised. We recommend that the cleaning method and schedule for washing floors be reviewed and amended to ensure that people are not placed at risk.

Is the service effective?

Our findings

People told us they were well cared for. One person said, "They look after me very well"

People were provided with a choice of suitable nutritious food and drink and told us they were happy with the quality of food and the choices available. One person said, "Usually the food is good. We get plenty and I can ask for a drink whenever I like." One relative told us that there was always fruit available and another said, "The food looks good and [my parent] eats it all and drinks a lot."

There was a four weekly rotating menu which included details of potential allergens. The service was able to cater for a variety of dietary needs. At the time of the visit this included diabetic, vegetarian, soft and pureed diet. People's dietary needs were indicated on the menu request form which was sent to the kitchen each day with people's meal requests for the following day. The chef made some desserts suitable for people with diabetes and the food supplier were being changed to ensure that a better range of diabetic foods were available. We saw that for pureed diets each food was pureed and served separately to enable them to enjoy the different tastes. Notes on people's specific preferences were also on the request form. For example one person liked a banana every day and another a jam sandwich three times a week. Therefore people were supported to have meals that met their needs and preferences.

One person with diabetes had a care plan supporting their need to keep a range of snacks in their bedroom. We saw that people were offered drinks throughout the day. Some people ate independently and others needed assistance from staff. When there were concerns about a person's weight or dietary intake we saw that advice was sought from the relevant healthcare professionals.

We observed lunch time on each of the three units and found that the quality of the meal time experience and of the support provided was not consistent. Lunchtime was a very busy period as in some units people needed a lot of support. In some cases we saw that people received good support with staff sitting next to them, talking to them and helping them to eat at their preferred pace. However, we also saw a member of staff giving a person their food too quickly. Another person's relative told us, "[Staff member] is kind, but does not give [my relative] the chance to swallow. They need to take their time." Although condiments were available they were not on the tables and were only given when asked for. In some units drinks were given with the meal but in others they were not offered until after the meal. The menu for the day was written on a small whiteboard near the serving area but this was not easily visible for people. There was a shortage of china and some people had their deserts in plastic or disposable bowls. The manager was aware of the shortage of china and new items had already been ordered. We recommend that lunchtime arrangements be reviewed, changed and monitored to ensure that people are fully supported and that mealtimes are a more pleasurable experience.

People were supported to access healthcare services and their healthcare needs were met. We saw that appropriate requests were made for input from specialists such as a speech and language therapist, dietitian and palliative care practitioners. People's healthcare needs were monitored and addressed to ensure that they remained as healthy as possible. There was a culture of diligent skin care as routine. Any

pressure ulcers were treated effectively with support from the tissue viability nurse when needed. One person had redness on the sacral area and there was a timely turning routine in place to help alleviate this and prevent deterioration. One member staff told us, "We take pressure sores seriously. Sometimes they come in with them, but we work hard to heal them." Another said, "We regularly check skin during personal hygiene time, and we look for any problems. Then we work to limit progress of problems and aim for recovery of good skin integrity." Medical visit forms were completed each time a person was seen by a healthcare professional. This meant that there was a record of people's healthcare needs and any recommended action or treatment.

People were supported by staff who received the necessary training to enable them to provide an effective service that met their needs. For example, we saw staff effectively supporting a person whose behaviour became challenging. They approached the person calmly offering reassurance and then successfully distracted and calmed them before supporting them to return to their room. This situation was well-handled with the person's dignity protected and other people nearby were kept safe. Staff told us they received an induction when they first started working at Moreland and ongoing training. Training included manual handling, fire safety, infection control, safeguarding, dementia awareness, Deprivation of Liberty Safeguards and the Mental Capacity Act. They told us it was the right training for the job that they did. There was a training schedule in place with further training scheduled in October and November 2016 to cover any outstanding updates and also to train staff who had been recently employed.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that most staff had received MCA and DoLS training and further training had been arranged for October 2016. For people with DoLS in place these had been agreed, by the relevant supervisory body. The manager was aware of how to obtain a best interests decision or when to make a referral to the supervisory body to obtain a Deprivation of Liberty Safeguard (DoLS). Records confirmed that when necessary applications for DoLS had been made to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

Staff told us that the manager was approachable and supportive. Staff received supervision (one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service.) approximately every three months. Most supervision had been carried out by the manager but senior staff had recently received supervision training to enable them to provide staff supervision and to make the supervision system more effective. Systems were in place to share information with staff including handovers between shifts and staff meetings. Therefore people were cared for by staff who received support and guidance to enable them to meet their assessed needs.

The service was provided in a large purpose built building in a residential area. It was newly built on the site of one of the provider's smaller homes which was then demolished. We saw that the environment was designed to meet the needs of the people who used the service and was accessible throughout for people with mobility difficulties. It was also designed to be 'dementia friendly'. The person responsible for the

design and building of the service had attended a dementia design course and had used this knowledge when planning the new building. Adapted baths and showers were available on all floors and specialised equipment such as hoists were available and used when needed. People lived in an environment that was suitable for their needs.

However, although people's names were on the doors to their rooms these had not been personalised to support those living with dementia. For example, with photographs or memory boxes. Also a recent healthwatch visit had recommended that when re-decorating, consideration be given to contrasting colours, in particular between walls and door frames, again to assist people living with dementia. Although the overall building was designed to support people with dementia we recommend that further consideration be given to making the interior decoration and signage more dementia friendly.

Is the service caring?

Our findings

People were positive about the care and support they received. They told us they were well cared for. Comments included, "They give me excellent care. I couldn't find fault with it," and "The care here seems quite good. They seem kind."

People told us that staff treated them with dignity and respect and that they were consulted if a member of staff was about to assist them with a task. Their privacy and dignity were maintained. Staff told us they used screens to preserve people's dignity when they were using the hoist to transfer them from their chair to their wheelchair or vice versa. During the course of the inspection one person became agitated and was in a state of undress. Staff used a sheet to cover the person until they were okay to return to their room and to be helped to dress.

Staff supported people in a kind and gentle manner and responded to them in a caring and respectful way. For example, we saw a member of staff patiently support a very frail person from their room to the dining table. They were at the person's side giving reassurance. When they reached the table the staff asked if they were ready to sit down before moving the chair and helping them to sit. They then asked if it was okay to push the chair in before adjusting it. A relative said, "The carers seem very kind."

Although there had been new staff in post recently the staff we spoke with knew the people they cared for. One relative said "They seem to know [my parent] well. Quite often when we come in, there'll be someone sitting with them."

People's personal information was kept securely and their confidentiality and privacy was maintained. We saw that individual files were kept in the nurses' station, which was a small room next to the lounge area.

Staff supported people to make daily decisions about their care as far as possible. We saw that people made choices about what they did, where they spent their time and what they ate. 'Residents' and relatives' meetings had taken place. People were encouraged to remain as independent as possible and to do as much as they could for themselves. For example, to eat independently.

When needed the service provided care and support to people at the end of their life. This was in conjunction with the local hospice and the GP. At the time of the visit nobody was receiving end of life care. However, we saw that one bereaved family had written to the provider thanking them for the care, love and compassion shown to their relative especially in the last few days before they passed away. Another had written to thank a member of staff who had visited their relative on their day off and spent time with them. They went on to say that their relatives care before they passed away was "above expectations."

Is the service responsive?

Our findings

People who used the service and their relatives were positive about the way the staff responded to their needs. One person told us that they preferred to sleep in their special chair and had asked staff to remove the bed. This had been done and the person assured it would be available again if ever they needed it. The room had been rearranged as the person wanted it and they were happy to have this support in creating the environment they wanted.

People's individual records showed that a pre-admission assessment had been carried out before they moved to the service. Information was also obtained from other professionals and relatives. The assessments indicated the person's needs and gave staff the initial information they needed to enable them to support people when they started to use the service. One person told us they had had an assessment and felt they were involved in their care then and subsequently.

Each person, including people who were using the service on a respite or short break basis, had an individual care plan which set out the care and support they needed. Although care plans covered a range of needs they were not always sufficiently detailed or clear. For example, for a person with diabetes there was an information sheet about diabetes and standard information about managing diabetes but no details as to the specific needs or issues for that person. For another person there was not a plan in place detailing how the reduction of one to one support, due to their behaviour, was to be managed. However, following on from care plan audits the manager had highlighted the need for improvements in care plans and had put a plan in place to address this. They had allocated care plans to senior staff to review and amend and arranged one to one training on care plans to support them to understand what was required.

People were not always aware of their care plans. For example, one person said, "I don't know much about care plans but I trust them here. They look after me well." A relative told us, "We're not aware of any care plan. Nothing was discussed with us when [my parent] came." People and their relatives told us that they did not have a keyworker (a named member of staff who acts as a focal point for the person and their relatives/visitors.) This meant that people did not always know who to approach with queries or concerns they might have. However, the manager told us that they had allocated keyworkers to each person and that people would be given details within the next week or two.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. People told us that they could make choices about their care and support. They said they chose when to get up and when to go to bed. There were locks on the bedroom doors, it was the person's choice if they locked their bedroom door or left it open. One person said they preferred their door to be open at all times and another said they knew there was a lock but would never use it. We saw that people were consulted and staff asked their permission before doing things for them.

We saw that the service's complaints procedure was displayed on notice boards in communal areas. Complaints were logged and actioned by the manager or area manager. A relative who had made a formal complaint in the past felt that the issues they complained about were much better now and that the service

had been responsive. Relatives and 'resident' meetings were held and this also gave people an opportunity to give feedback about the service and any concerns they might have. One person said they attended such a meeting and another said they didn't bother to go. One relative also spoke about "three monthly meetings to discuss things." People used a service where their concerns or complaints were listened to and addressed.

However, not everyone was aware of how to complain or who to complain to. For example, one person told us, "I haven't got any complaints but don't know who I'd talk to. I think there's somebody on the ground floor." Another said, "I haven't had any complaints. I wouldn't know who to speak to." A relative said, "We don't know about the complaints procedure. The admin person gave one of us the name of the boss, I think." We recommend that systems be put in place ensure that people know how and who to complain to should the need arise.

Arrangements were in place to meet people's social and recreational needs. A full time activity worker was in post to support this. Activities included games, art and crafts, exercises, films and music. People told us that they enjoyed the exercise activity. One said, "I like doing exercise with [activity worker] and they also walk with me in the garden." Another said, "The exercises were fun." There was a large garden with a covered veranda and during the afternoon people gathered there for a birthday celebration. This included singing and a birthday cake. There was also a raised bed to encourage people to 'garden' and a lavender bed had been planted for sensory stimulation. Celebrations were held with the most recent being a summer garden party.

Is the service well-led?

Our findings

There had not been a registered manager in post since May 2015. At the time of the last inspection an experienced manager from another of the provider's services was managing the service. Another manager was appointed but left the service before their registration application was processed. The current manager was in the process of registering with CQC.

There were clear management and reporting structures. The manager had previously been the deputy manager and therefore another deputy manager had recently been appointed. In order to further strengthen the management of the service, team leader posts had been created and recruitment to these was ongoing. People informed us that they were happy with the new management of the service and felt comfortable raising any concerns when they arose. One person said they felt the manager was responsive and effective. A relative told us that the culture in the service, as compared to a few months ago, was "very different now." They added that they had confidence in the management team and trusted them.

Staff also spoke positively about the new management arrangements. One member of staff commented, "I find my manager very approachable, and I love my job. We are a good team." Another said, "[The manager]" is supportive and approachable. I can go to them without any fear.

The manager monitored the quality of the service provided which ensured that people received the care and support they needed and wanted. For example, one person told us that earlier in the day the manager had been to see them to ask how they were. The person was concerned about one of their medicines running out and the manager promised to sort it out. They had returned later to say that more medicine was being obtained later in the day."

The manager also carried out audits in different areas. For example, care plans, infection control, falls and pressure ulcers. We saw from these audits that issues had been identified and action was being taken to address them. For example, additional care planning training was taking place.

The provider had systems to monitor the quality of service provided. The manager was required to complete a monthly computerised quality report, completed audits, accident reports, complaints and other issues were recorded on a shared drive and senior managers of the organisation monitored these. Provider monitoring visits were carried out and a report written indicating what they had looked at and their findings. A new quality assurance/area manager was in post and they had carried out the most recent monitoring visit. The report indicated the action required and the date for completion and they told us that this would be followed up at future visits to ensure that action had been taken.

The provider also sought feedback from people who used the service and stakeholders by means of an annual quality assurance questionnaire. Responses from this were analysed and plans put in place to respond to any issues that had arisen. People were consulted about what happened in the service. They were asked for their opinions and ideas. The provider visited the service most weeks and spent time talking to people about any issues or concerns they might have. In addition 'residents' and relatives meeting were

held. People were listened to and their views were taken into account when changes to the service were being considered and implemented. People used a service which sought and valued their opinions which were listened to and acted on to improve and develop the service. For example, the manager was allocating key workers to people following on from a relatives meeting.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely managed and this placed people at risk of harm from their medicines. Regulation 12 (1) (2) (g)