Langley Court Rest Home Limited

Langley Court Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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 inspection took place on 18 and 19 August 2016 and was unannounced. At our last inspection on 21 January 2016, we found breaches of the regulations in relation to governance and staffing. We imposed two requirement notices. At this inspection we checked to see if the provider had taken action to address these.

Langley Court Rest Home is a residential care service for up to 28 people, including those living with dementia. At the time of our visit there were 22 people using the service. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the provider had taken the necessary action to make sure staff received regular supervision to support them in carrying out their roles. All care staff had received supervision in the last three months and training was up to date. Staff had opportunities to study for relevant qualifications to broaden their knowledge about social care work.

Care plans did not always take into account people's long-term care needs such as mental health conditions and incontinence. We also found that care plan updates did not always take into account the ways in which people's needs changed over time. We found a breach of the regulation in relation to person-centred care. You can see what action we have asked the provider to take at the back of this report.

The provider had a range of audits in place to check the quality and safety of the service. These included audits of safety, medicines and care plans. However, the care plan audit had not identified that some information about people's long-term or changing needs was missing from care plans.

We found the provider was not displaying their CQC rating, which is a legal requirement. However, when we informed managers of this they made sure it was done promptly.

People told us they felt safe. The home had appropriate procedures in place to protect people from abuse and report suspected abuse. Staff were familiar with these. People had risk assessments and management plans in place to identify and mitigate risks to their safety, whilst helping them retain their independence as much as possible. There were enough staff to care for people safely and the provider carried out appropriate checks during the recruitment process to help ensure staff were suitable.

The provider regularly checked the premises, equipment, moving and handling techniques used by staff and fire safety precautions to make sure these were safe and effective. There were procedures in place to manage emergency situations. The provider also had appropriate arrangements in place for the safe storage of medicines. Stock balance records and medicines administration records indicated that people received their medicines when needed.

Staff obtained people's consent before carrying out care tasks. Care plans contained information to help staff do all that was reasonably possible to help people understand the information they needed to consent to their care. If people did not have the capacity to consent, the provider followed the processes that are legally required by the Mental Capacity Act (2005) to ensure that decisions made about people's care, including any restrictions on their freedom, were made in their best interests and did not compromise their rights.

People received a variety of food and drink that met their needs and preferences. Where people did not want the dishes that were offered, the kitchen staff met their requests for alternative choices. Staff monitored people who were at risk of malnutrition to make sure they ate enough to stay healthy. People had access to the healthcare support they needed, including referrals to other services when needed.

People and their relatives said staff were kind and caring. We observed staff interacting with people in a friendly and respectful manner. Staff gave people the support they needed when they were upset or in pain. People were involved in planning their care and had the information they needed to make decisions about how they lived their lives. Staff respected people's choices and supported them in line with the choices they made. Staff respected people's privacy and dignity. People and their relatives gave examples of how they were supported to remain as independent as possible within the context of the care they received.

There was information in people's care plans about their preferences around how their care was delivered and how they liked to spend their time. There was a dedicated activities worker and people were able to participate in a range of group and individual activities that met their needs and provided them with meaningful occupation.

The service had a complaints policy in place. People and their relatives told us the manager listened to any concerns they had, although they had not felt the need to make any complaints. The service had not received any complaints since our last inspection.

The provider systematically sought people's opinions about the service and asked them about ways in which it could be improved. They had made several changes in response to people's feedback, such as improving the laundry service and the quality of hot meals. The provider had plans to improve the service further and they shared these with people who used the service.

The provider collected information about accidents and incidents. They used this to learn lessons, share these with staff and improve the safety of the service by taking action to prevent them from happening again.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were procedures in place to recognise and report suspected abuse.

The provider assessed and managed risks to people's safety, both individually and at service level.

There were enough staff to keep people safe and the provider carried out appropriate checks to help ensure they were suitable to care for people.

Medicines were managed safely.

Is the service effective?

Good

The service was effective. Staff received the support they needed from supervision, training and regular meetings.

Staff obtained people's consent before providing care. The provider complied with the requirements of the Mental Capacity Act (2005) to ensure decisions made on people's behalf were in their best interests.

People received enough nutritious food to keep them healthy. They had access to healthcare services when they needed them.

The home was decorated and structured in a way that was intended to meet the needs of people using the service, although the provider had plans to improve this further.

Is the service caring?

Good

The service was caring. Staff treated people with kindness and respect and offered reassurance when they needed it.

People received the information they needed to make choices about their care and staff respected the choices people made.

Staff respected people's privacy and dignity and worked with them to promote their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some care plans did not contain the necessary information about how to meet people's long-term needs and care plans were not always updated to reflect changes in people's care needs.

People were able to take part in a range of group and individual activities during the day.

People and their relatives said the manager listened to any concerns they had. There was a complaints policy in place but the service had not received any complaints since our last inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led. Although the provider had a range of audits to assess the quality of the service, including care plan audits, they had not found the problems we found with missing information in care plans.

The provider had plans to improve the service and they involved people in developing these. They asked people for their opinions about the service and made changes as a result of their feedback.

The provider learned lessons from accidents and incidents, shared these with staff and acted on them to improve the safety of the service.

Langley Court Rest 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 inspection took place on 18 and 19 August 2016 and was unannounced. One inspector carried out the inspection.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and notifications of events the provider is required by law to tell us about. We also looked at the action plan the provider sent us to tell us about improvements they were making after their last inspection. We contacted the local authority safeguarding team that had been working with this service.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four people who used the service, four relatives of people who used the service and three members of staff. We also spoke with the registered manager, deputy manager, a representative of the provider organisation, a visiting healthcare professional and a visiting social worker. We also looked at four people's care plans, five people's medicines records and four staff files. We received online feedback after the inspection from one person's relative who was not able to be present during the inspection.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe using the service. One person said, "It's my home. I definitely feel safe here." Another person's relative told us, "I feel [my family member] is very safe here."

At our last inspection of the service in March 2016 when answering the key question 'is the service safe?' we found the provider in breach of the regulation in respect of safe care and treatment. The risks to people from falling from height and from hot water temperatures were not always identified and managed appropriately and the risks to a person of financial abuse had not been assessed and managed robustly. Although the provider took prompt action to address the concerns and stated in their action plan they sent to us in March 2016 that they had already done this, we checked them again at this inspection because we wanted to make sure the provider consistently maintained the required standards over time.

At this inspection, we found the provider was managing risks appropriately. There was information about the fire evacuation procedure displayed so people, visitors, staff and any other person could see it. People had personalised emergency evacuation plans so that staff and firefighters were aware of how to assist each person to leave in an emergency. An alarm system was in place and alarm pull cords were available in toilets and bathrooms so people could alert staff if they needed help. Staff checked these regularly to ensure they worked. Equipment, including lifting equipment, was checked and serviced regularly and managers carried out a monthly health and safety check looking at the premises, equipment and the techniques used by staff to assist people to move. Window restrictors were in place to prevent people from falling from windows. Staff tested hot water temperatures monthly to make sure people were not at risk of scalding from hot taps. These things helped to ensure that premises and equipment were safe for people to use and that staff were using approved moving and handling techniques that kept people safe while being supported to move.

Each person had risk assessments for risks such as developing pressure ulcers, moving and handling and falls. These contained information for staff about how to protect people from these risks. Where risks were assessed as being low, risk management plans still contained personalised information about how to prevent the risk from becoming higher. For example, staff were to prompt one person who was assessed at low risk of developing pressure ulcers to move regularly to ease the pressure on parts of their body. We observed staff offering this person the opportunity to go for a walk at different times during the inspection. This showed that staff were following the person's risk management plan. There were assessments for risks specific to individuals, such as one person with a history of behaviour that challenged the service, who had a risk management plan to help staff keep the person and others safe. The risk management plans were designed to keep people safe while allowing them to remain as independent as possible and contained information about what people could safely do for themselves.

The home had a policy and procedure on safeguarding people from abuse, which contained information about how to prevent abuse, recognise the signs of abuse and report suspected abuse. We asked staff about this and found they were familiar with it. This helped to protect people from abuse because staff were aware of how to prevent and report suspected abuse.

Relatives told us staff responded well to accidents and emergencies. One relative said, "If [person] falls, they don't mess about. They get medical help and they let us know." There were processes in place to respond to and learn from incidents. Following an incident that happened during the night, staff were required to check people hourly at night. The manager told us this was an interim safety measure as they were in the process of assessing each person's needs to establish how often each person needed to be checked. We looked at accident and incident records and according to these no major incidents had occurred in the last six months. Staff had recorded minor incidents and records contained the information managers needed to identify any trends or patterns that might indicate unmet needs or risks that needed better management.

Relatives told us there were enough staff to meet people's needs and there was "always someone about." We observed staff interacting with people throughout our inspection. There were enough staff to attend to people's needs and people did not have to wait for staff to become available if they wanted help. Rotas from the four weeks before our inspection showed that the current staffing levels had been met every day. The registered manager told us they observed staff caring for people on a daily basis to ensure there were enough staff to meet people's changing needs. Staff told us they were able to raise any concerns about staffing levels with the manager.

Managers told us how their recruitment procedures were designed to make sure staff were suitable to work with people. This included close supervision and monitoring for their first few shifts. They told us new staff were not allowed to assist people with personal care during this time, until their supervisor was satisfied that they were able to care for people safely. We checked staff files and found the provider carried out checks such as criminal record checks, identity checks and references, to help ensure staff were suitable to work with people.

Medicines were stored securely, either in locked trolleys attached to a wall, in a locked wall-mounted cabinet if they were controlled drugs, or in a locked refrigerator if they required refrigeration. Staff recorded daily the temperatures of areas where medicines were stored. All temperatures recorded in the month leading up to our inspection were within the safe range for storing medicines and a thermometer in the medicines storage area indicated it was at a suitable temperature. This showed that medicines were stored safely.

We checked stock levels for five people's medicines, including controlled drugs, and found they corresponded with records. The five people's medicines administration records indicated that people received their medicines as prescribed. Staff recorded when they received supplies of controlled drugs. These and all instances where staff administered controlled drugs were signed by two members of staff, which was in line with medicines administration guidance and helped to ensure any errors or omissions would be identified quickly. Where people had medicines to be taken only when required, there were guidelines for staff about when people should take the medicines, how much and how often they could take them and other instructions such as whether they should first seek advice from a GP or another competent person. This helped to ensure that people received their medicines safely and in line with medical advice.

Good

Is the service effective?

Our findings

At our previous inspection, we found that staff did not receive the necessary supervision and appraisal to enable them to carry out the duties they were employed to perform and there were some gaps in staff training. We received an action plan from the provider in March 2016 telling us they had already addressed this and staff were receiving supervision. At this inspection we saw records showing that all care staff had received supervision within the last three months. Managers told us that appraisals had not been completed, but explained that this was because they had addressed training and development needs at supervision rather than having separate appraisal meetings. We looked at a sample of supervision records to confirm this. We spoke with a member of staff who had recently joined the service and they told us they received a comprehensive induction with training on a variety of subjects they needed to know about before providing care to people. This helped to ensure staff had the support they needed to carry out their roles effectively. We saw evidence that staff attended training courses on a variety of subjects, including specialist training to help them meet the specific care needs of people using the service. Staff also received up to date training on mandatory subjects such as mental capacity awareness and moving and handling.

The registered manager told us about regular meetings they attended to keep their knowledge about best practice in social care up to date. We also saw evidence that several members of staff were working towards different qualifications relevant to their work. These included vocational qualifications, nurse training and care planning courses. Staff told us they shared their learning with the rest of the team to help broaden their colleagues' knowledge and ensure staff were aware of current best practice in their field.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (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.

Relatives told us staff sought people's consent before providing care. One relative said, "If [my relative] doesn't want to do something they don't make him." We also observed staff asking people if they wanted support with various tasks and then only helping them if the person indicated that they did. This showed that staff respected people's choices when they did not give consent for the proposed care. People's care plans contained information about their mental capacity in general, for example whether they had any cognitive impairments that may affect decision making, although the care plans also made it clear that staff should consider each decision about people's care separately and involve people as much as possible. The information was personalised and included whether people were able to retain information or understand consequences, how much explanation they might require in order to understand things and what decisions they were generally able to make. We saw evidence that 'best interests' meetings took place to make important decisions on behalf of people who had been found not to have capacity to make them for themselves. This was in line with the MCA Code of Practice and helped to ensure that people's consent was sought before care took place and that decisions were only made on people's behalf if they were genuinely

unable to do so themselves.

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. There was a policy on DoLS that all staff were required to read so they understood their roles and responsibilities with regard to DoLS. Where people were deprived of their liberty, we saw evidence that their capacity was assessed to judge whether they were able to consent to the care provided by the home and if not, the provider had followed the DoLS requirements and obtained authorisation from the relevant bodies.

People told us they liked the food served at the home. One person said, "I like the food here. They make anything I want." Relatives told us the food "looks and smells nice" and that a good variety of dishes was available. We spoke with the cook on duty, who gave examples of how they changed the menu for people who did not like or were unable to eat certain foods and said they were able to meet requests. The cook named several people and told us about those people's preferences and needs. We later spoke with one of those people, who confirmed that the cook knew what they liked. The person told us they were "very choosy" but enjoyed the food they received at the home. At lunchtime, we observed one person refusing the main meal and staff asked them what they would prefer. The person requested a sandwich, which was delivered to them promptly. This showed that people were able to choose from a range of food that met their dietary needs.

Staff weighed each person monthly and recorded any weight loss or gain. This meant they could monitor this aspect of people's health and ensure people received adequate nutrition to maintain their weight. We saw that people who had been assessed as being at risk of malnutrition had charts where staff recorded what they had eaten and how much. We also observed staff looking at how much people had eaten at lunch and recording it, which the cook told us they used to monitor people's likes and dislikes as well as how much they ate. This helped staff quickly observe any concerning changes to people's eating habits.

One person's relative told us staff were knowledgeable about their relative's long-term health condition and were good at liaising with other health professionals when needed. We saw evidence that people received support to access healthcare providers and other professionals as required. This included referrals to a dementia service and a pain clinic, district nurse visits for people at risk of pressure ulcers and regular podiatrist checks for people who were at risk of developing foot problems. People confirmed that they were able to access healthcare providers, including specialist services where relevant.

The home was decorated in pastel colours with ornaments and pictures on display, including people's own artwork. Managers told us people had helped choose the colours when the home was redecorated. The home had several communal areas and a garden that people could choose to spend time in, either alone or with others. This meant people were able to access private space, for example to spend time with visitors, without being restricted to their bedrooms. It also meant people were able to choose whether to participate in group activities or pursue individual interests. The provider told us the open-plan design of the communal space was specifically created to help people with dementia feel comfortable and facilitate easy movement from place to place. This helped ensure the environment was suitable for people and helped them feel at home.

There was a board displayed in a communal part of the home with information about what date and day it was, the season and weather and any birthdays being celebrated. Each person had their own place mat in the dining area and these were hand-decorated with the person's name and pictures of things they liked.

These were designed to aid people's orientation.

Good

Is the service caring?

Our findings

People and their relatives said staff were caring and respectful. One person said, "I get on very well with staff. I like them all. They make jokes with me and they respect me." Another person's relative told us, "[Relative] always looks nice. Her nails and hair are always done and her clothes are nice." We observed that people in the home were wearing clean, weather-appropriate clothes and suitable footwear. Another relative said, "They are so nice, so caring, all of them." We saw staff smiling at people and sharing jokes with them.

Staff gave people the emotional support they needed. One person told us they experienced untreatable pain and that staff were kind and supportive about this. We had earlier observed the person crying out in pain and saw that staff went and spoke with them sympathetically. Another person's care plan stated that they sometimes felt anxious, how staff would know when it happened and what they should do to help the person feel calm and reassured. This helped staff maintain positive relationships with people because it enabled them to understand and meet people's emotional needs.

There was evidence that people were involved in planning their care and relatives confirmed this was the case. For example, people filled in forms stating whether they preferred male or female staff to support them with personal care. This showed that people and their relatives were actively involved in making decisions about how they should be cared for.

We observed staff giving people information about what was happening in the home and offering them choices. For example, staff informed people that we were carrying out an inspection in their home and we heard staff telling people that they had appointments with the dentist who was visiting the home. When one person said they did not understand why they should see the dentist, the member of staff explained why it was important and gave the person information about the consequences of not doing so. However, when the person then decided they did not want to see the dentist, staff respected the person's choice and told the person they could see the dentist next time they came. Another person told us staff had encouraged them to give up or cut down on smoking and had offered them smoking cessation aids. They told us they had chosen to carry on smoking despite being fully aware of the health risks, which they were able to describe to us. We also saw copies of information that people and their relatives had received about proposed installation of closed-circuit television (CCTV) equipment in communal areas of the home, along with the provider's CCTV policy. The provider told us they would not go ahead with the proposal unless people and their relatives agreed to it, having had time to read and understand the information. This demonstrated how staff gave people the information and support they needed to make choices about their care and treatment, even if people did not choose what staff felt was best for them.

During our inspection, several people had appointments with the visiting dentist. Although dental examinations took part in a communal part of the home, a screen was used to maintain people's privacy and ensure other people could not see or overhear them during their appointments. We saw staff giving one person medicines that they took with food and they did this discreetly and out of view of other people who used the service, to maintain the person's privacy around their medical treatment. Staff gave examples of how they maintained people's privacy while supporting them with personal care.

One person told us, "I go for walks with staff and I am working towards going independently." Another person's relative told us staff were good at encouraging their family member to remain as independent as possible and gave examples of how they did this. Care was planned in such a way as to promote people's independence. For example, one person's care plan directed staff to remind them to use the toilet when they needed to but not to provide further support with this unless the person asked for it. This helped staff to meet people's needs without compromising their independence.

Requires Improvement

Is the service responsive?

Our findings

People told us care was tailored to their needs. One person said, "It's flexible here, not regimented. They cater for everybody's needs." Relatives told us, "Care here is about what the person wants. There are activities [person] likes and they can make choices." A visiting professional told us the service was particularly good at caring for people living with dementia although it sometimes struggled to meet more complex needs. Relatives told us the registered manager and deputy manager had visited them before their relative started using the service to gather information about the person's needs and to provide reassurance about the transition from their own home to the care home.

Care plans addressed some of the needs that were identified at these visits. For example, people diagnosed with long-term conditions such as dementia had care plans to manage these. People with diabetes whose blood sugar levels needed monitoring as part of their care had records of these on file. There was information about what signs staff should look for that might indicate deterioration in these people's conditions and what they should do in response. However, some care plans did not contain this information. For example, one person's assessment stated that they had a long-term mental health condition but there was no care plan to instruct staff about how to meet the person's mental health needs, how to tell if their condition deteriorated and what action they should take. Three out of four people who needed support around continence did not have continence care plans so staff knew how to meet their individual needs in this area. This meant we could not be sure that all people who used the service received care that was responsive to their needs.

Care plan reviews took place monthly and were intended to ensure that care plans remained up to date with people's needs as they changed over time. This included monthly skin integrity assessments to check for any changes in the level of support people needed to prevent them from developing pressure ulcers. We saw that on some occasions care plans were updated with new information about how to meet people's needs, such as information added from reviews with healthcare professionals about long-term health conditions. However, when people's needs changed there was not always enough information added to the care plan to show staff what changes they needed to make in the person's care. For example, two people's reviews showed their needs were increasing with regards to their continence, but there was no information about what assistance they needed or how this should be done to meet their preferences. One of these people had a continence care plan, but although their daily notes demonstrated that staff regularly assisted them with incontinence pads and that they were "soaking wet" with urine on two mornings on the week of our inspection, the care plan had not been updated with information about what continence care they required such as what type of pads they used and how often they should be changed. We did not see evidence that staff had referred either person to a continence service to assess their needs. This meant there was a risk that care was not person centred and people's needs were not met because the service was not taking into consideration how these changed over time.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had supplied information about their preferred waking and bed times and how they liked to spend their time. Relatives told us they were involved in a discussion about the person's likes and dislikes as part of care planning. We also saw information in care plans about people's interests, hobbies and social needs, such as whether they preferred to have their own space or spend more time socialising. The service had a dedicated activities worker, who we saw leading activities throughout both days we visited. Before the activities worker arrived, people told us about them and said they looked forward to their arrival. We saw the activities worker telling people about the group activity they were about to start and asking whether they wanted to join in.

People told us they enjoyed participating in activities at the home. During the inspection, we observed group activities taking place. There was music playing from an era appropriate to the age of people using the service. There were quizzes, which we observed people taking part in with apparent enthusiasm. Records showed that people had opportunities to participate in a variety of group and individual activities almost every day. These included games and puzzles, arts and crafts, church services, dancing, exercises and walks. Some people had been watching the Olympic Games, which were taking place around the time of our inspection. Records showed when people declined activities that they were offered. This helped staff gather information about what people usually liked to do and what they enjoyed less. There was also a well-equipped hairdressing salon in the home where a hairdresser visited twice a week and people told us they enjoyed being "pampered." These activities contributed to meeting people's social, health and religious needs and provided them with meaningful occupation during the day.

Relatives told us they would be happy to express any concerns they had, although they did not have any at the time of our inspection. One relative told us they were confident to approach the registered manager and deputy manager and that "they listen." We looked at complaints records and noted there were none since 2014, which managers confirmed. The complaints policy and residents' charter were displayed so people and their visitors had information about how to complain. We looked at the complaints procedure and saw it contained clear information about what people could expect to happen if they complained. However, we noted that the copy on display was in small print and not in an accessible format for people with visual or cognitive impairments. We fed this back to managers, who said they would look into ways of providing accessible information to people.

Requires Improvement

Is the service well-led?

Our findings

When a service has been inspected and rated by the Care Quality Commission, the provider is required by law to display their rating on their website where applicable and conspicuously on the premises where people and visitors can see it. We noted that this service did not demonstrate they were fully meeting this legal requirement by displaying its rating on its website and we did not see it at the home. We spoke with the deputy manager, who saw that the displayed rating was covered by another item on a noticeboard. They placed the information where people could see it and amended the website on the day of our inspection to show the rating. We will continue to check that the provider is meeting this legal requirement.

We saw the registered manager carrying out a scheduled medicines audit during our visit. Records showed that staff also checked medicines stock levels every 8-10 days to make sure people received their medicines appropriately. We looked at some other audits the provider carried out monthly. These included the monthly health and safety check, audits of staff training, checks of medicines management and records and audits of people's care plans. We saw an example of records showing action the provider had taken in response to a report of poor care observed by a member of staff. They had taken appropriate action in line with their disciplinary procedure to improve the quality of care delivered by that member of staff. The above showed that the provider had systems in place to assess the quality of the service they provided, identify areas for improvement and act on them. However, the care plan audit did not find the problems we identified with regard to missing information about some people's long-term or changing needs. We discussed this with the registered manager, who said they would look at care plans again and make sure the missing information was added.

People and their relatives told us they were happy with how the manager ran the home. They demonstrated that they were aware of the provider's plans to improve the service. One relative said, "They pay attention to what needs doing and they do it" and told us that if people wanted things to change at the home then the provider responded to their requests.

Staff said the managers were "good people" and always made time to answer any questions they had. They told us the managers gave them extra training if they requested it and that they were able to express their views about the service. We saw evidence that staff attended monthly meetings where they could discuss incidents and how to prevent them from happening again, good practice in social care and proposed improvements to the service. This helped to ensure all staff were aware of what they should do to provide good quality care.

The registered manager explained that they did not currently hold regular residents' meetings as these had not been successful in the past and people did not find them helpful. Instead, they gathered people's views by speaking to them informally and asking them for their opinions about the service. The provider also carried out a survey of people's opinions about the service two months before our inspection. They asked people about the quality of the information they received, whether staff treated them with respect and dignity, whether they were involved in making decisions about their care, the quality of food and whether they knew how to complain. They also asked people for suggestions about how to improve the service.

People mostly fed back positively, but made some suggestions about improving food, activities and the laundry service. Managers told us about what they had done in response to this, including extending the hours of the member of staff responsible for laundry, working with kitchen staff to ensure cooked food was not prepared too early so it always arrived hot and new activities they had introduced including a music quiz that happened during our inspection. This demonstrated that the provider made use of systems to monitor the quality of the service they provided and that they involved people in making decisions about improvements to the service.

The provider told us about other improvements to the service that they were planning. This included the addition of indoor and outdoor sensory-based activities. They told us they regularly attended meetings with other providers and quality improvement forums to help them gather ideas of how they could improve the service. Policies and procedures were updated at least annually to ensure the information they contained was still relevant and in line with current best practice.

The provider gave examples of lessons they had learned from incidents and improvements they put in place as a result. These included the installation of fingerprint scanners to provide evidence that staff checked on people at night, following an incident where a person was not checked when they should have been. They told us the registered manager and deputy manager carried out unannounced night visits to check whether staff were keeping people safe at night.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not make sure that people's care and treatment met their needs. They did not design care in such a way as to ensure this. Regulation 9(1)(b)(3)(b)