Clyde House Limited

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Inspection report

330 Wellington Road North
Heaton Chapel
Stockport
Greater Manchester
SK4 5DA
Tel: 0161 432 8677
Website: Carefirsthomes.com

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection was carried out over two days on 27 and 29 October 2015. Our visit on the 27 was unannounced.

We last inspected Clyde House Limited on 10 September 2014. At that inspection we found that the service was meeting the regulations we assessed.

Clyde House is registered to provide personal care and accommodation for up to 17 adults with mental health conditions. There is a lounge, dining room and kitchen on the first floor and there are bedrooms and bathrooms on all three floors of the property.

The home had a manager registered with the Care Quality Commission (CQC) who was present on both days of the inspection. 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.

Summary of findings

We identified five breaches 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 this report.

People who used the service, who we asked, said they felt safe living in the home.

Staff who we asked demonstrated a good understanding of the need for safeguarding procedures and their role in them.

Although people who used the service told us they felt safe we found some areas in the home where people's safety was being compromised.

We looked at the way in which medicines were managed. The records of the administration of medication did not give us confidence that medicines were always being managed safely.

We found that systems in place to check and respond to environmental risks, such as the fitting of window restrictors and carrying out risk assessments of individual bedrooms were not always effective which meant potential health and safety issues were not always detected or addressed.

Although all rooms had been portable appliance tested (PAT) many of the items brought into the home after PAT had been carried out, had not. This could place both people using the service and staff at risk of potential damage to their health.

The head housekeeper told us that due to the nature of the service, people did not always allow the housekeeper's into their rooms, making it difficult to maintain a good level of cleanliness. In two bedrooms we entered we could see that the bedding was extremely dirty and in need of laundering. Other bedrooms looked in need of deep cleaning and in need of re-decoration and re-painting.

On checking the laundry facilities in the home we found that staff did not have access to a soap and paper towel dispenser following after dealing with soiled linen. Lack of maintaining appropriate levels of cleanliness throughout the whole home and lack of appropriate equipment to help maintain hand hygiene could place both people using the service and staff at risk of potential infection and cross infections.

People spoke positively about the staff who they felt were kind and caring and we observed good interactions between the staff and people who used the service.

Staff had access to a range of appropriate training and received supervision on a regular basis and felt management to be approachable and supportive.

People's care plans contained sufficient information to guide staff on the care and support people required. Where able, people had been involved and consulted about the development of their care plans. This helped to make sure people's wishes were considered and planned for.

Care records seen indicated that people using the service had access to other health and social care professionals, such as social workers, doctors and mental health specialist.

We saw that appropriate arrangements were in place to assess and monitor if people were able to consent to their care and treatment and staff we spoke with had a good understanding of the care and support people required.

Records were kept of the food served and, when necessary, we saw action had been taken, for example a referral to other health care professionals such as a dietician or speech and language therapist, if a concern had been identified.

People who used the service had access to a complaints procedure and knew who to speak with should they have any concerns, worries or complaints.

The registered manager told us that they monitored and reviewed the quality of service on a monthly basis by carrying out audits (checks) on all aspects of the management of the service for example, care plans, infection control, medication and the environment. During our examination of these completed audits, we noted that none of the concerns we raised during this visit about medication, the environment and infection control had been 'picked up' during the monthly audit process.

Summary of findings

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.

The management of medicines was not always carried out in a safe way.

Some parts of the home required further work to make sure people were kept safe and free from harm. For example, there was a lack of appropriate environmental risk assessments being in place and a lack of appropriate methods of infection control and a lack of cleanliness being maintained throughout the premises.

Suitable arrangements were in place to help safeguard people from potential abuse. Staff had received training in the protection of vulnerable adults.

A robust system was in place for the recruitment of staff.

People living in the home told us that enough staff were on duty to support them when needed and that they felt safe.

Is the service effective?

Good

The service was effective.

Staff told us they had received appropriate induction training and received regular training that helped them to update their knowledge and skills and safely care and support people using the service.

We were told that, and records seen confirmed that wherever possible, if people using the service had capacity, they would be involved in planning their care and treatment.

Care records seen showed that people using the service had access to other health and social care professionals, such as doctors, district nurses, mental health services and community practitioners.

People who used the service, who we asked, told us that staff were supportive, good at their job and know what they are doing.

Is the service caring?

Good

The service was caring.

The staff we spoke with demonstrated they had a good understanding of the care and support people required.

We saw staff responding quickly to people's request for support.

Staff respected people's private space and knocked on doors before entering.

People's responses to staff showed they knew the staff and trusted them.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

Staff who we spoke with had a clear understanding about the need to respond to the individual.

A system was in place to record and address any concerns or complaints made.

Care records contained sufficient information to guide staff on the care to be provided. Records were reviewed regularly and care plans updated when a person's individual needs changed.

Is the service well-led?

Requires improvement 

The service was not always well-led.

There were systems in place to monitor the quality of service provided. However due to the shortfalls found during this inspection, improvements were needed.

They were systems in place to consult with the people who used the service.

The service was currently led by a manager who was registered with the Care Quality Commission (CQC) since August 2015.

Staff told us that the management team were approachable and very supportive.

Clyde House Limited

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 the 27 and 29 October 2015 and the first day was unannounced.

The inspection was carried out by one adult social care inspector.

Prior to an inspection taking place, we usually request that the provider completes a Provider Information Return (PIR). This is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We did not, on this occasion, send a PIR to the provider for completion. However, before our inspection we reviewed the previous inspection reports and all the information we held about the service. We spoke with local commissioners who, at that time, had no concerns about the service.

During this inspection we spoke with four people who used the service, two team leader support workers, one support worker, the care manager, the registered manager and the provider. This enabled us to obtain their opinions about the service being provided. We looked around most areas of the home, observed how staff cared for and supported people, looked at two people's care records, six medicine administration records, four staff personnel files, training records and records held about the management of the home.

Requires improvement

Is the service safe?

Our findings

We found that people using the service were not always fully protected against the risks associated with the management of medicines. We looked at medication administration records for five people.

Medicines were stored safely in a large, locked metal cabinet which was within a locked medication room. Most people using the service asked staff for their medication when it was required, with trained staff administering medicines to those who needed support with this area of their individual assessed needs. On occasions, people were not ready, or did not want to take their medicines and we saw that support workers would return at a later time to reoffer them.

Most medicines on the records we examined indicated that medicines had been administered correctly. However we did find instances where it was unclear if medicines had been given as the staff responsible had not signed the record to confirm this. We were told that medicines prescribed to be given 'as and when required' such as paracetamol were only ordered when required and any balances at the end of the month were carried forward to the next month's record. We checked three records where this type of medicine had been prescribed. On checking the remaining balances of tablets against the record, it was found that balances did not correspond with the number of tablets administered. This meant there were some records where there were more tablets left than recorded as being administered, and some records that showed less tablets left that had been recorded as administered.

We also found one instance where a person using the service was an insulin controlled diabetic. There was one day where no administration record had been completed to show that the person had received their insulin as prescribed. If the person had not received their insulin they could have been at risk of having a diabetic seizure, resulting in medical attention being urgently required.

One person using the service self-administered their own medication. This person had previously administered their own medication but had been re-assessed as being unsafe to do so and staff had supported them with this. Since that time, the person had started to self-administer their own medication again. No re-assessment had taken place, no risk assessment was in place and the care plan did not reflect that this matter had been reviewed and updated. Lack of up to date and appropriate information being available for all staff could mean this person was at risk of not maintaining their prescribed medicine regime or could be at risk of taking too much medication.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Due to the nature of the service, during our tour of the premises we did not enter all bedrooms as some people would have been distressed by this.

We looked around the building and found that appropriate window restrictors needed fitting to two windows. These would then prevent the windows being opened too wide and creating a potential falling risk to people using the service. We spoke with the registered manager about this who told us they would check all windows throughout the premises and ensure appropriate window restrictors would be fitted where still needed. Specific guidance about such restrictors can be obtained from the Health and Safety Executive (HSE). It is the provider's responsibility to ensure people using the service are kept safe and free from potential harm.

This was a breach of Regulation 15 (1) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Most bedrooms seen were extremely full of personal belongings, with some people continuing to purchase items from second hand shops and the like on a daily basis. Some of the items purchased were of an electrical nature, such as 'second hand' adaptors, radios and other appliances. Although all rooms had been portable appliance tested (PAT) many of the items brought into the home after PAT had been carried out, had not. This could place both people using the service and staff at risk of potential damage to their health. No room risk assessments had been carried out. It is the provider's responsibility to ensure people using the service are kept safe and free from potential harm.

During our tour of those bedrooms we were able to enter, we could see that some people had been smoking and drinking alcohol in their rooms, which went against the organisations policy and procedure about no smoking and

drinking alcohol on the premises. No risk assessments had been carried out. It is the provider's responsibility to ensure people using the service are kept safe and free from potential harm.

This was a breach of Regulation 12 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

In our conversation with the head housekeeper, we were told that due to the nature of the service, people did not always allow the housekeeper's into their rooms, making it difficult to maintain a good level of cleanliness. In two bedrooms we entered we could see that the bedding was extremely dirty and in need of laundering. Other bedrooms looked in need of deep cleaning and in need of re-decoration and re-painting.

Toilets and bathrooms were clean and had hand soap dispensers and paper towel dispensers. The lounge, dining room and kitchen were found to be clean and were cleaned on a daily basis, with cleaning schedules being maintained.

The laundry for the service was sited in the basement of the home. Although there was a porcelain sink that would enable staff to wash their hands after dealing with soiled linen, no soap dispenser or paper towel dispenser was available to use. Lack of maintaining appropriate levels of cleanliness throughout the whole home and lack of appropriate equipment to help maintain hand hygiene could place both people using the service and staff at risk of potential infection and cross infections.

Support workers had access to personal protective equipment such as disposable vinyl gloves and plastic aprons. We saw such equipment being used throughout our visit to the service.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with two people who used the service about staffing levels in the home. Neither person expressed any concerns and both felt enough staff were on duty at any one time to support them. One person said, "Yes, the staff are good. I like living here. I've been here five years and I like it. [named staff] helps me to have a shower. I like living here; it is safe for me and the others."

Staff rosters indicated that staffing levels remained consistent and any sickness or holiday absence was covered by existing staff. Discussions with the staff on duty showed there were sufficient suitably experienced, trained and competent staff available at all times to meet people's needs. One staff member told us, "Staffing levels have improved and a change of rota has meant we have more days off in one block, so our own staff can pick up vacant shifts as overtime. This helps to provide consistency to the resident's. We no longer use any agency staff."

We looked at four staff personnel files and saw a safe system of recruitment was in place. The recruitment system helped to protect people from being cared for and supported by unsuitable staff. The files contained application forms that documented a full employment history, a medical declaration, two appropriate references and a Criminal Record Bureau (CRB) check or a Disclosure and Barring Service (DBS) check. These checks help the service provider to make an informed decision about the person's suitability to work with vulnerable people. The files also contained proof of identity, such as, a photocopy of a birth certificate, passport and utility bills. Where this evidence had been obtained, the person reviewing the documentation should sign and date each part as confirmation.

We saw that disciplinary action had been taken where staff had breached policies and procedures relating to their poor conduct during their employment with the service.

Suitable arrangements were in place to help safeguard people from harm and potential abuse. Examination of the staffs training plan showed all staff had received training on the protection of vulnerable adults. Policies and procedures for safeguarding people from harm were in place and available for staff to access. The staff we spoke with were able to tell us what action they would take if they witnessed or suspected abuse.

Staff we spoke with had a clear understanding of whistle-blowing and knew they could contact people outside of the service if they felt their concerns would not be listened to or taken seriously. Having a culture of openness where staff feel comfortable about raising concerns helps to keep people who use the service safe from harm.

Accidents and incidents were recorded and the registered manager assessed this documentation on a monthly basis.

Requires improvement

Is the service safe?

The provider of the service also spoke with the manager on a monthly basis and requested an update on action that had been taken and for the outcomes of such action. Records seen confirmed this.

There was a Business Continuity Plan in place, including a business impact analysis. This provided staff with details of contacts in the event of emergencies such as loss of utility services, and total evacuation of the premises.

Good

Is the service effective?

Our findings

We asked people using the service to tell us about the skills and attitude of the staff working in the home. Comments made to us included, "I don't have any problems with any of the staff. They are all good at their job and know what they're doing" and "I've heard the staff talking about doing some training, so I suppose they do. I like living here and I like the staff, I don't want to move."

When we spoke with one of the senior staff we asked them to tell us how they made sure people received safe care and support that met their individual needs. We were told that before a person was admitted to the home, a detailed assessment was carried out to make sure the person's individual needs could be met by both the staff and the service. We saw details of pre-admission assessments on the care files we looked at.

Those staff who we spoke with told us they had received appropriate induction training when they started working at the home. They also told us they had access to, and received regular, appropriate training and that they had just received information about what updated training was being arranged for them. The registered manager provided us with a training matrix and training certificates for the staff working in the home. Information contained in the plan indicated that staff had completed training that helped them to safely care and support people using the service and that training was planned on an ongoing basis. Regular training for all staff is important to support and further develop them to carry out their jobs safely and effectively.

All staff who we spoke with confirmed that they received supervision sessions with their line manager. One member of staff told us, "Supervision is happening on a much more regular basis now, along with the [staff] meetings we have." Records seen indicated that formal one to one supervision were ongoing on a regular basis and annual appraisals were taking place. Supervision meetings support and help staff to discuss their progress at work and also discuss any learning and development needs they may have.

To make sure effective communication took place between all staff, records seen indicated that information about people living in Clyde House was handed over between night and day staff and between the care manager and team leaders. We saw records that showed these meetings were taking place. One member of staff told us, "We all work well as a team and we can speak with [named] care manager or [named] registered manager at any time." The care manager takes on the responsibility of managing the service in the absence of the registered manager.

We asked both the registered manager and care manager to tell us wheat arrangements were in place to enable the people who used the service to give consent to their care and support. Both told us that any care, treatment or support provided was always discussed and agreed with people who were able to consent. The people who we spoke with confirmed this information was correct. People told us they were able to make decisions about their daily routines and were able to give consent to the care and support they needed. One person told us, "I have my friends to visit and the staff bring them to my room" and "[named] support worker, asks me if I want a shower, sometimes I do, sometimes I don't , but they don't make me." We also saw evidence that where able, people using the service had signed a consent form agreeing to care and treatment. We also observed staff asking people what they would like to do or if they required any support before any action was taken.

From our observations and looking at the care records it was evident that some people using the service were unable to give direct consent to the care they were being provided with. We asked the registered manager to tell us how they made sure any care and support provided was done so in the best interest of the person. We were told that if an initial assessment, or information was shared, that a person did not have the mental capacity to make decisions then a 'best interest' meeting would be arranged. A 'best interest' meeting is where other health and social care professionals, and family members if relevant, meet to discuss the best course of action to take to make sure the best outcome can be achieved for the person who used the service. We saw evidence of such details on one care plan file we examined.

In our discussions with both the registered manager and the care manager they were able to tell us about their understanding of the Mental Capacity Act 2005 (MCA) and the work that that been carried out to determine if a person had the capacity to give consent to their care and support. The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Deprivation of

Good

Is the service effective?

Liberty Safeguards provide a legal framework to protect people who need to be deprived of their lberty in their own best interests. At the time of our visit to the service no applications for legal authorisation of DoLS had been made for any person living in the home. Training records and certificates showed that all staff had completed training in both MCA and DoLS with further training planned.

Care records seen indicated that people using the service had access to other health and social care professionals, such as social workers, district nurses, general practitioners, community psychiatric nurses and mental health specialists.

People had a choice of foods from a varied menu displayed in the dining room of the home. The nature of the service meant that most people did not have a set meal time and came for their meals when they felt ready to eat and staff prepared their meal individually. Staff we spoke with told us that there was no one living in the home that required any particular assistance to eat their meals, but may need encouragement to eat regularly. We saw that the dining experience was a sociable and relaxed, people were helped to maintain as much independence as possible. The dining room was set up to promote independence enabling people to prepare their own drinks and access snacks throughout the day, we saw those people with the ability, taking advantage of this.

Records were kept of the food served and, when necessary, we saw action had been taken, for example a referral to other health care professionals such as speech and language therapists or dietician, if a concern had been identified.

Good

Is the service caring?

Our findings

People we spoke with, who used the service, were complimentary about the support workers. Comments made to us included, "All the staff are good and kind" and "I'm well looked after, no problems."

We saw that some people were better groomed and better dressed than others. However, due to the nature of the service it could be difficult to encourage some people to wash and dress on a regular basis and support workers we spoke with told us about the techniques they used to try and encourage people to maintain their personal hygiene. This information was also seen in the care plans we examined.

Support workers responded quickly to people's request for support and we saw where one person in particular wanted a shower, action was taken to facilitate this to happen straight away to make sure the person's personal hygiene was being maintained. Once showered, this person came back in to the dining room looking clean and smart and told us he had enjoyed his shower and liked [named] support worker helping him.

We saw support workers treating people with dignity and respect. People moved freely around the home and we observed positive interactions between people and support workers. We heard support workers chatting to people and providing words of encouragement especially about matters relating to daily living, involving them in decisions and asking them on their individual needs and choices.

People's choices and preferences were met. We saw that one support worker who had finished working the night shift, responded to a person's request to get him some curried goat for a meal later that day. The support worker responded to this request by calling at the relevant butcher's before going home and bringing the meat back to the home.

As we moved around the home we saw that both support workers and housekeepers knocked on people's doors before entering and respected the person's personal space. The housekeeper on duty told us, "We cannot always get access to a person's room to clean it on a regular basis so we do the best we can and do a little at a time when the person allows it."

We asked support workers how they provided people with person centred care. They were knowledgeable about people's individual needs and were familiar with the contents of people's care plans and associated records. They gave examples of how they provided support and did their best to promote people's independence and choices. During our observations we saw positive interactions taking place between support workers and people who used the service. Support workers spoke with people in a friendly and respectful manner.

People who used the service had regular opportunities to speak with the care manager about how they were finding things living in Clyde House. Most people did not like attending a larger meeting, so to make sure people were provided with an opportunity to discuss the running of the service, and to make shared decisions, the care manager spoke with each person individually on a regular basis. Records were kept of these meetings and any matters arising and actions taken as a result.

Where people who used the service needed support to express their opinions or discuss their healthcare needs at reviews, we saw that other health and social care professionals, such as mental health specialist acted as advocates for the person when required.

Good

Is the service responsive?

Our findings

Those people who used the service, who we spoke with, told us they felt their needs were being met. One person told us, "I'm happy, yes, I'm happy with everything." Another person said, "It's all right living here, I ask one of the staff when I need something and they will help me."

The registered manager and care manager described the service's referral and assessment process. The initial support plans / packages were mainly devised by local authority social services or mental health teams, based upon their assessment of people's needs. Prior to admission to the home, information was then gathered from the person, and other sources, such as health and social care professionals, families or from staff involved at other placements. Arrangements would then be made to visit the prospective service user and complete an initial assessment on behalf of Clyde House. This assessment would be completed by the care manager or registered manager of the service.

We looked at two people's support plans and associated care records. The information identified people's needs and provided guidance to the staff team on how to meet and respond to those needs. Information included a 'lifestyle history' on the person's background; it also described their likes, dislikes and preferred choices. Where people using the service had been involved in developing their care file and care plan information, they had signed the relevant documentation. Daily logs (Progress Evaluation Sheets) were kept to report on, monitor and respond to people's wellbeing. Staff 'handover' meetings were held to share and update support workers on any changes to a person's wellbeing or health.

Evidence was available to demonstrate that the care plan structure was comprehensive and each person's care plan was reviewed monthly. Care plans covered areas relevant to the individual person and included details such as their physical and mental health status, nutritional needs, social needs, and details about their medication. This detailed information provided clear guidance to support workers in how to deliver care and support to the individual. We saw that care plans also included associated risk assessments where it was deemed necessary, including management strategies. At the time of our inspection, the registered manager and care manager were in the process of reviewing a new care plan format.

During our visit we noted there was no 'structured' activity programme for the service. However, we did observe that most people who used the service preferred to spend time in their room or go out and visit the local community. Support workers told us that some people like playing games such as dominos or cards and others liked watching television or listening to music, but most preferred their own company. Where people invited us into their rooms to speak with them, we could see they were enjoying activities personal to them, including playing cards, watching television and videos and listening to their radio. This demonstrated that people's preferred choices and lifestyle preferences were happening and were being respected.

We asked one support worker how they prevented social isolation for people. They told us, "By making sure you still involve them in the daily routines, like taking them a drink to their room, encouraging them to talk, encourage them to join people for meals and things like that."

We looked at how the service responded to and managed concerns and complaints. The people we spoke with, although could not remember what the complaints procedure involved, told us they would speak with support staff or [name] the registered manager. One person said, "I would tell [name], he's the manager and would sort things out, I know he would." The complaints procedure was displayed in the hallway of the home but did not include contact details for the Local Authority or Local Government Ombudsman.

Requires improvement

Is the service well-led?

Our findings

The service had a manager who was registered with the Care Quality Commission (CQC) in August 2015 and was present throughout both days of the inspection process. The registered manager also had responsibilities for another service in the organisation, but was accessible to both services on a day to day basis.

We asked both the registered manager and care manager to tell us how they monitored and reviewed the quality of service to make sure people received a safe, effective and a responsive care service. We were told that monthly audits (checks) were undertaken on all aspects of the management of the service. We were provided with evidence of some of the audits that had been previously undertaken, for example on care plans, infection control, medication, and the environment. At the end of the monthly audits document was room to record if any improvements were needed, action to be taken and by whom. These actions would then be checked the following month. During our examination of these audits we noted that none of the concerns we raised during this visit about medication, the environment and infection control had been 'picked up' during the monthly audit process.

The lack of robust systems being in place to monitor the quality of service people received was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service, who we spoke with were aware of who the management team of the service were and did not express any concerns about the management arrangements.

The management team consisted of the registered manager, care manager and team leader support workers. The care manager was able to confirm her role, responsibility and accountability in the absence of the registered manager, as were the team leaders in the absence of the registered and care manager.

We saw evidence to demonstrate that 'handover' meetings were undertaken on each change of staff shift to help make sure that any known changes in a person's condition was properly communicated.

Meetings between the registered manager and care manager took place on a daily basis, where all aspects of the daily management of the service was discussed and reviewed. The provider (owner) of the service visited the home at least once per week to meet with the registered manager and also to talk with both people using the service and staff. The provider visited the home during our inspection and chatted to us about their future development plans for the service.

We saw that management had previously sought feedback from people who used the service and their relatives through annual questionnaires. However, it was found that the response to these questionnaires was almost always nil. It was therefore decided that the care manager would speak with each person who used the service on a one to one basis each month. This was to make sure people had the opportunity to discuss the running of the service and any concerns they may have. This was done individually and confidentially and not all the people wished to participate but records seen indicated that this was working well. No feedback questionnaires had been sent to staff or any health and social care professionals.

Policies and procedures were up to date and were accessible to staff and guidance in their development was sought from a professional health care consultancy. We saw that the policies and procedures available had been reviewed on an annual basis.

Staff who we asked understood the culture and value base of the service. We were told that the registered manager expected people who used the service to be respected and treated as individuals.

Staff also told us that the management team were approachable and very supportive. Comments made to us included, "Yes, I think the service is well-led. Opportunities are created to have open discussions with the management about the service. The registered manager is approachable, fair and supportive, but if he's not happy with something he will tell you" and "At this present time I'm very happy and in a good place. I feel much supported and [named registered manager] has got the service to a point where he wants it to be."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 We found that the provider had not protected people against the risks associated with the safe administration and management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All parts of the premises used by the service provider to provide accommodation to people using the service were not secure. Regulation 15 (1) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because part of the premises used to accommodate people were not risk assessed. Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not always protected against the risks associated with poor hygiene and cross infections due to a lack of effective infection control and prevention measures being in place in all parts of the home. Regulation 12 (2) (h)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have sufficient and effective systems in place to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b)