The Glynn Residential Home Limited

The Glynn Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 April 2016 and was unannounced.

We previously inspected the service on 28 and 29 April 2015 and at that time we found the registered provider was not meeting the regulations relating to management of medicines and managing risk. We asked the registered provider to make improvements. On this visit we checked to see if improvements had been made

The Glynn Residential Care home is a privately owned home registered to care for up to 38 people over the age of 65. Accommodation is in single rooms in a large converted house over two floors. At the time of this inspection there were 32 people using the service.

The service is required to 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 2008 and associated Regulations about how the service is run.' The service had a registered manager.

People who lived at The Glynn told us they felt safe.

We found medicines were not always managed in a safe way for people. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment

Staff had a good understanding about safeguarding adults from abuse and who to contact if they suspected any abuse, Risk assessments minimised risk whilst promoting people's independence.

There were enough suitably trained staff to meet the assessed needs of people who used the service.

People's capacity was not always considered when decisions needed to be made because some people who lacked mental capacity had not been considered for Deprivation of Liberty (DoLS) authorisation to ensure their rights were protected in line with legislation. This was a breach of regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent.

People were supported to eat a good balanced diet and people enjoyed the food served. A range of healthcare professionals were involved in people's care as the need arose.

People's individual needs were met by the adaptation, design and decoration of the service.

Staff were caring and supported people in a way that maintained their dignity and privacy and people were

supported to be as independent as possible in their daily lives.

People's needs were reviewed as soon as their situation changed. People and their representatives were involved in care planning and reviews.

People told us they knew how to complain and told us staff were always approachable.

The registered manager had an overview of the service. They audited and monitored aspects of the service, however this system had not picked up and addressed the problems we found. This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

The culture of the organisation was open and transparent and the managers were visible in the service.

The care manager held meetings with people who used the service, relatives and staff to gain feedback about the service they provided to people.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed safely.

Staff had a good understanding of safeguarding adults from abuse.

Identified risks to people were managed well.

There were enough suitably trained staff to meet the assessed needs of people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity was not always considered when decisions needed to be made in line with legislation and guidance.

Staff had received specialist training to enable them to provide support to the people who lived at the Glynn.

People were supported to eat and drink enough and maintain a balanced diet.

People had access to external health professionals as the need arose.

Is the service caring?

Good

The service was caring.

Staff interactions with people were supportive, caring and enabling.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

People and their representatives were involved in the development and the review of their support plans.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service's quality assurance systems had not addressed problems we found at the inspection.

The culture was positive, person centred, open and inclusive.

The manager held meetings with people who used the service, relatives and staff to gain feedback about the service they provided to people.

The Glynn Residential 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 20 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider and feedback from the local authority safeguarding and commissioners. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection. Before this visit we had received information of concern about poor moving and handling practices and staffing levels.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with six people who used the service, two relatives and two community professionals. We looked in the bedrooms of six people who used the service with their permission. We also spoke with four members of care staff, the managers on duty who were the care manager, the home manager and the office manager. The registered manager was not present on the day of our inspection and we spoke with them afterwards. During our visit we spent time looking at four people's care and support records. We also looked at three records relating to staff recruitment, training records, maintenance records, and a selection of the service's audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and visitors we spoke with told us they felt confident their relative was safe at The Glynn. People who used the service said, "Yes it's safe. I put my lock on sometimes." "Yes it's safe. I used the buzzer once when I was ill and the staff came."

Our previous inspection found the registered provider was not meeting the regulations relating to the management of medicines because medicines were not always stored safely. On this visit we checked to see if improvements had been made. We found medicines were stored safely, however we found there was an absence of robust stock control measures and some people's medicines were not administered as prescribed.

We carried out an audit from a random sample of seven medicines dispensed in boxes or bottles. On five occasions we found discrepancies which indicated people were not being administered their medicines as prescribed. For example we saw on 4 April 2016, 28 tablets were dispensed and recorded as being received on the Medicines Administration Record (MAR) sheet. Signatures on the MAR sheet indicated 17 tablets had been administered yet instead of 11 tablets remaining we found 13 in stock. This indicated on two occasions the medicine had been signed as being administered but had not been. The home manager said they would introduce a daily audit immediately to address the concerns.

We saw medicines were administered in a manner which did not comply with the prescriber's instructions. For example some people were prescribed medicines which had to be administered before, with or after food. We saw three people were administered medicines after breakfast whilst the instructions showed they should have been administered 30 to 60 minutes before food. This meant there was a risk these medicines might not work properly which could affect a person's health and wellbeing. All medicines for a time of day were dispensed in a sealed pod. The pod contained medicines which could be administered after food and others which had to be administered before food. The care manager told us they would address this method of dispensing with the pharmacy to support good practice.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs could be accounted for. However we found evidence of poor record keeping. The care manager told us they would reinforce to care staff the need for accurate record keeping of controlled medicines.

We saw some MAR sheets were handwritten and on some occasions the MAR sheet had not been signed by a second member of staff. This meant there was no evidence to indicate a staff member had checked to ensure the details recorded were accurate.

We found there to be no consistent approach to providing guidance to staff in the administration of PRN (as required) medicines. A PRN protocol provides guidance for staff to ensure these medicines are administered in a safe and consistent manner. The care manager said they would address this.

The care manager told us senior carers at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw senior carers completed medicines competence assessment annually. We saw one member of staff had not completed refresher training or medicines competence since November 2014. The home manager told us they would address this. This meant people did not always receive their medicines from people who had the appropriate knowledge and skills.

The above issues meant medicines were not always administered in a safe way for people and evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found two people did not have their prescribed medicines available to be administered. We found the care manager had repeatedly tried to resolve the situation with the GP. Whilst the situation was unsatisfactory we found the care manager had taken the appropriate and timely actions to resolve matters.

People's medicines were stored safely. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use.

Creams and ointments were dated upon opening found to be in date. The applications of creams were recorded on a separate sheet containing a body map. Allergies or known drug reactions were clearly annotated on each person's medicine records.

Staff told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. One staff member said, "If I saw anything of concern I would report it to the manager". Staff gave us a description of the different types of abuse they may come across in their work. Staff told us they had confidence in the managers and were sure any concerns they may have would be acted upon. They were also aware they could report externally to the local authority and to the Care Quality Commission. This showed staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

At our last inspection on 28 and 29 April 2015 we found the registered provider was not meeting the regulations relating to managing risk. We asked the registered provider to make improvements. On this visit we checked and found improvements had been made.

People's care plans included any necessary risk assessments based both on actual and perceived risk. The identified areas of risk depended on the individual and included issues such as skin integrity, mobility, nutrition and health needs. The home used recognised assessment tools for looking at areas such as nutrition and skin integrity. We saw where risks had been found, risk reduction strategies had been identified. For example, one person was shown to be at risk should they leave the home unaccompanied. The provider had assessed the person's mental capacity and applied and been successful in gaining a Deprivation of Liberty Safeguards (DoLS). In addition we saw the Herbert Protocol had been completed. The Herbert protocol is a local police force initiative which encourages carers to compile information which could be used to assist the search in the event of a vulnerable person going missing.

Staff told us they recorded and reported all accidents and people's individual care records were updated as necessary. The care manager and staff members were able to describe the procedure to follow and explain what action had been taken following falls and incidents. We saw accidents and incidents were recorded and appropriate action was taken to ensure the safety of people who used the service. For example, referrals were made to health professionals such as 'my therapy' for advice and further support and this advice was followed up. We saw the registered provider kept a log of incidents and had analysed accidents and incidents across the service to look for themes and lessons learned.

Before this inspection we received information of concern regarding sufficient staffing levels at the Glynn. Relatives and people who used the service told us there were usually enough staff on duty. A person who used the service said, "There are two or three staff in a morning. Everything happens at once. There are enough staff, but some of the young ones need more training." One visitor said, "There is always someone about. It can get a bit hectic. They get on with it"

We saw there were sufficient numbers of staff on duty to meet people's needs. At busy times, such as lunchtime, people chose where they wished to eat and so staff deployment was spread over four rooms, making it more difficult for staff to provide immediate attention to people if they needed it. On the day of our inspection the home manager and the care manger were supporting people to eat. We saw ancillary staff, such as the chef, maintenance staff and cleaning staff were present during our visit. We saw from rotas there were at least three care staff on duty throughout the day every day, as well as ancillary staff and at least one manager.

The provider had their own bank of staff to cover for absence. This meant people were supported and cared for by staff who knew them well.

A series of risk assessments were in place relating to premises and equipment, for example: kitchen safety, water temperatures, use of bedrails, waste disposal, slips, trips and falls, moving and handling equipment, waste disposal and hazardous substances and staff we spoke with were aware of these.

We saw documents were maintained in relation to premises and equipment. We saw checks for passenger lifts, hoists, gas safety, electrical installations and portable appliance testing (PAT) had been completed. We saw servicing and maintenance of equipment such as hoists had been completed regularly and was up to date. This showed the registered provider had taken steps to provide care in an environment that was adequately maintained.

We found the majority of radiators at the home were covered; however two radiators in the main entrance were not covered and were hot to the touch. The care manager told us they repeatedly turned these radiators off but a person who used the service turned them back on. The care manager agreed to take action to protect people from the risk of injury from hot surfaces.

We found the home to be well maintained and in good decorative condition. However we found the absence of a lock on the ground floor bathroom door which failed to afford people privacy. A member of administrative staff told us the damage was listed for repair.

People who used the service and staff told us they knew what to do in the event of a fire and fire drills were completed regularly. This showed us the home had plans in place in the event of an emergency situation. We saw from records that fire alarm tests and fire door checks had been completed regularly and checks on fire safety equipment were up to date.

We saw from staff files that safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Requires Improvement

Is the service effective?

Our findings

People who used the service, relatives and staff told us they were asked for consent and records confirmed this was the Case. For example we saw one person had been offered a 'flu' jab. The person had been asked if they wanted the treatment and their response was documented in the care plan. We saw a statement in people's care records which showed they would be helped to exercise their rights to participate in government and local elections. In addition we observed staff seeking consent to help people with their immediate needs.

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 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.

We saw two people were subject to DoLS, one of whom had conditions attached to the authorisation. We saw the DoLS with conditions had been granted by the supervisory body for six months to provide the opportunity for the managing authority to implement the conditions. The authorisation had two conditions attached both of which were designed to ensure every opportunity had been taken to maintain and improve family relationships and contact for the person. Our observations of care plans indicated the conditions were not being acted upon. A discussion with the care manager confirmed This and the care manager assured us a review of the person's care needs would be undertaken without delay.

We also spoke with the care manager about other people at the home whom our observations indicated may need to be assessed and an authorisation sought for DoLS. Discussion with the care manager and entries in care plans suggested some people lacked capacity to make the decision to live at the home and would be prevented from leaving should they wished to do so. We saw staff needed to know the whereabouts of some people at all times to protect them from harm as they lacked insight into the potential risks to their safety. This meant people were potentially being deprived of their liberty without a legal framework being in place. The care manager assured us people's needs would be assessed and if appropriate, authorisations for DoLS would be submitted. This meant people's capacity was not always considered when decisions needed to be made in line with the Mental Capacity Act (2005) and guidance.

The above issues evidenced a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff were provided with training and support to ensure they were able to meet people's needs effectively.

Staff told us they completed an induction including a week of training and two weeks shadowing with more experienced staff before starting work at the service. Staff recruitment and training records confirmed this to be the case.

We saw evidence in staff files and training records that staff regularly undertook training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. Staff told us, and we saw from training records, they had completed training in areas including moving and handling, fire safety, health and safety, catheter care, The Mental Capacity Act, safeguarding, infection control and equality and diversity. Training was a mixture of computer based and practical face to face training.

Staff told us they felt supported. One staff member said, "The managers have been fantastic." Staff told us they had regular supervision, as well as an annual appraisal, and supervision records confirmed this. Staff supervision records were minimal in content and recorded three supervisions on one sheet. However, we saw staff were given the opportunity to comment during supervision and staff discussed future professional development and training.

People who used the service told us they enjoyed the food and were supported to eat a balanced diet. "They have lovely food in here." "The food is lovely." "The food. I've no worries there." "Yes. It's nice".

We saw people made choices in what they wanted to eat and drink from the menu at lunch time and were able to request food they preferred. The cook said, "If residents want it we order it. Someone asked for current tea cakes for breakfast so we ordered them." Records showed people had an assessment to identify what food and drink they needed to keep them well and what they liked to eat.

We saw staff supported people who needed assistance to cut up their food, or who needed assistance to eat their meal. We saw staff were using appropriate cutlery to ensure food could be consumed easily. Staff were patient and no person was rushed to eat their meals. Staff demonstrated they knew each person's needs and preferences in terms of food and drink.

We observed the addition of food supplements and fortification to people's meals in line with the requirements described in their care plans and the individual dietary requirements of people were catered for. We saw food and drink was offered to people throughout the day. We saw snacks of sweets, crisps and biscuits were offered to people and one person told us they enjoyed running a tuck shop where people could choose snacks.

People had access to external health professionals as the need arose. One person who used the service told us, "I had an ear infection. They reported it straight away and the doctor came out." We saw several health professionals were visiting people who used the service on the day of our inspection. Staff told us systems were in place to make sure people's healthcare needs were met. They said people attended healthcare appointments and we saw from people's care records that a range of health professionals were involved. This had included GP's, hospital consultants, community nurses, chiropodists and dentists. This showed people who used the service received additional support when required for meeting their care and treatment needs

Good

Is the service caring?

Our findings

People who used the service told us the staff were caring. They said, "They are lovely. They help me with everything. Large and small." "I couldn't ask for anything more. They are lovely people." "The care staff are alright. They are caring."
Some relatives told us, "They have really looked after (person)." "They are very good." "Care in here is second to none. Excellent place. All the staff are like family now."

Staff we spoke with told us they enjoyed working at The Glynn and supporting people who used the service. One staff member we spoke with said, "I like working here. It's nice if you are caring for people who haven't got anyone who comes to see them and you can bond with them."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways. We heard staff chatting with people about family members and activities they enjoyed.

We observed interaction between staff and the people who lived at the home. We heard staff asking people what they would like to do and explaining what was happening. We saw a carer suggested a person might like to move from the dining table after lunch to a more comfortable chair and supported them to do so. When they were sitting in an easy chair they put a foot muff on for the person to keep them comfortable. We saw a carer spoke with one person who was confused, touched their hand, bent to their level and reassured them.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. For example, staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care. This showed people were treated with respect and were provided with the opportunity to refuse or consent to their care and or treatment. Staff said, "We ask before starting personal care. Always ask permission." We saw people were well dressed and presented.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support. One staff member said, "We ask people. Always give them a choice." Meetings were held for people to attend and give their views on how the home was run and they commented on aspects of care such as food choices and activities. The care manager told us one person was without relatives or friends to help them make informed choices. Care plans showed the person had access to a professional advocate who visited regularly and provided support when care plans were being reviewed. We saw one person received a visit from the local church during our visit in line with their religious needs.

Staff were respectful of people's privacy; they knocked on people's doors and asked permission to enter. People's individual rooms were personalised to their taste, with family photographs and personal items, including their own furniture and personal bedding. Some people listened to music in their bedrooms and one person had their own telephone land line. Personalising bedrooms helps staff to get to know a person

and helps to create a sense of familiarity and make a person feel more comfortable.

On one occasion we saw staff were not attentive to a person's needs during activities in the lounge. Three staff members and an activity provider did not notice a person who used the service gently touching another person with a foam stick being used for activities. The person was becoming agitated and did not move away from the situation. We informed a senior care worker who was present in the room and the situation was resolved by supporting the individuals to move apart. Both people were appropriately supported after the incident and the home manager told us they would put measures in place to ensure this did not happen again. This meant on this occasion staff were not attentive to the person's needs and their dignity was not maintained.

People were encouraged to do things for themselves in their daily life. We heard staff encouraging a person to help themselves when getting dressed. We saw staff supported and encouraged a person to stand and use their walking frame and took time to provide reassurance and support to enable them to remain as independent as possible following a stay in hospital. This showed that people living at the home were encouraged to maintain their independence.

Some people had impairments of cognition which impacted upon their ability to make daily decisions and be involved in their care. The service had worked with relatives to develop life histories to understand the choices people would have previously made about their daily lives and what choices may have been made about the end of their lives. Where people had chosen to do so we saw end of life care plans were in place.

Good

Is the service responsive?

Our findings

Relatives we spoke with said, "We have just had a review. They contact me if anything happens." and, "Yes we are involved and invited to reviews."

One community professional told us, "The staff are always welcoming. They are very knowledgeable about the person and take on board all I ask them to do. The home supports people with mental health problems well."

The staff we spoke with had a good awareness of the support needs and preferences of people who used the service. Care records included a personal history and personal details were included for example, support with hair and make-up. This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

People were supported to make choices and decisions about their daily lives. Through speaking with staff and people who used the service we felt confident that people's views were taken into account. People told us they were involved in planning their care and we saw from care records this was the case. Where this was not possible or not desired by the person, their family and other relevant health and social care professionals had been involved. This meant the choices of people who used the service were respected.

In the care records we sampled we saw care plans were in place covering areas such as mobility, nutrition, communication, mood, sleep and personal care. We saw staff daily recorded outcomes of the care plan and took steps to modify the plan in light of people's experiences or changing health care needs. Care plans recorded what the person could do for themselves and identified areas where the person required support. Where people required support the care plan described this in terms of numbers of staff and any equipment needs. For example, one person's care plan described how they were to be moved with the help of a hoist. We witnessed the hoist being used and staff acting in accordance with the care plan and the training they had received.

The home manager said people's care plans were reviewed as soon as their situation and needs changed and every one to two months. We saw care plans were reviewed regularly, signed and up to date. These reviews helped in monitoring whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage

We found activities were provided at The Glynn for people who wished to participate. People who used the service said, "I don't go to the activities. I can go out if I feel like it." "They come in once a week with games. Someone came this morning. I went upstairs out of the way. I like listening to music."
A relative said, "They have quite a lot of activities. (Person) enjoys the singer. They are doing something for St George's day."

The office manager also co-ordinated some activities such as an occasional trip on a canal boat, monthly meals out, cheese and wine evenings and singers coming in to the home. They told us care staff played

bingo with people and a dance co-ordinator came in to do gentle physical activity with people.

People who used the service told us, "There is nothing to complain about" and "I complained about my bed the other day. She (the registered manager) got me a new one straight away." People who were able to do so and relatives, told us they would feel comfortable raising issues and concerns with any of the staff and they knew how to complain. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately, including any minor verbal complaints. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with were positive about the managers and told us the home was well led. People who used the service told us, "It's the best one around here." "They do look after you and you get good food." "It's such a lovely place."
One relative said, "I have never had a problem, but yes if I had they would act on it."

We found a number of audits were in place within the service. The medicines audits we saw had been completed twice a month, looked at one person's medicines on each occasion, contained minimal information and lacked rigor. These audits had not been effective in improving the quality and safety of medicines administration at the home. This was a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance because effective systems were not in place to assess, monitor and improve the quality and safety of the service provided to people.
We saw audits were maintained in relation to premises and equipment. Mattress audits had been completed on a regular basis as well as cleaning audits and care plans and documents were also reviewed regularly. We saw the registered provider had analysed accidents and incidents across the service to look for themes and lessons learned. However the audit system had not picked up and addressed the issues we found.
The managers regularly worked with staff directly providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported. The registered manager told us the aim of the service was to maintain a, 'comfortable, happy, friendly place where people could enjoy spending their later years within their local community'.

Staff we spoke with indicated there was an open and transparent culture in the home and they were motivated and clear about their roles and responsibilities. Staff told us they felt well supported and valued in their roles. They said there were regular opportunities for staff meetings and supervisions and their professional development was given high priority. We saw staff were motivated and committed to supporting the people who lived at The Glynn. The registered manager told us, "Everyone who works here is committed to the wellbeing of the clients. That is the ethos of the home."

The registered manager told us they attended good practice events, such as infection control and DoLS awareness, as well as being involved in the local independent sector liaison group, aimed at improving joint working within the area. This meant the registered manager was open to new ideas and keen to learn from others to ensure the best possible outcomes for people using the service.

The registered manager told us they encouraged links with the local community and church and held a summer fete, coffee mornings and parties to which family, friends, advocates and local organisations were welcomed. The registered manager said, "We are very much an open house."

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw a survey of service users' and relatives' views was sent out in January and July annually under the headings of Caring, Effective, Responsive, Safe and Well-led. The

outcome of the survey showed relatives were complimentary about the care and were appreciative of being included in decisions about their relatives' care needs. The care manager told us the survey was analysed by the registered manager and any learning from the survey was incorporated into the service plan.

The registered manager said, "This is their home. What people want they will get." The home held a weekly meeting in the lounge for relatives and people who used the service to discuss the running of the home, activities and menu choices. We saw at the last meeting plans for a fish and chip supper and the upcoming party for St George's day were discussed.

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 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 11 HSCA RA Regulations 2014 Need for consent People's capacity was not always considered when decisions needed to be made in line with legislation and guidance. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of the service provided to people who use the service. Regulation 17 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 always administered in a safe way for service users because appropriate arrangements were not in place for recording, dispensing and safe administration of medicines regulation 12 (2) (g)

The enforcement action we took:

Warning notice issued to comply by 30 June 2016