

Able Care (Menwinnion) Limited

Menwinnion Country House

Inspection report

AbleCare (Menwinnion) Limited
Lamorna Valley
Penzance
Cornwall
TR19 6BJ

Tel: 01736810233

Website: www.menwinnioncarehome.co.uk

Date of inspection visit:
19 January 2016
20 January 2016

Date of publication:
16 March 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This unannounced inspection took place on 19 and 20 January 2015. Menwinnion Country House provides accommodation and personal care for up to 34 people who do not require nursing care. On the day of our inspection there were 32 people living in the service and two people receiving respite care. Some people were living with dementia.

The service is a detached rural building in its own gardens in the west of Cornwall. Accommodation is available on two floors and the building was clean, appropriately decorated and well maintained.

The service did not have a registered manager. The registered manager had accepted a new role as the provider's training lead before our inspection. One of the service's existing deputy managers had been promoted to lead the home and had applied to the commission for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us they felt safe and well cared for at Menwinnion Country House. People said; "I think we get incredibly well looked after", "They really do look after us" and, "I feel safe here." People's relatives said, "The staff are charming and very attentive" while Health and Social care professionals who visited the service regularly said; "I do think people are safe here" and, "I don't have any concerns at all."

Risks were not effectively managed at Menwinnion Country House. Specific risks in relation to unrestricted windows on the first floor had not been appropriately assessed. We raised concerns about people's safety because of the absence of restriction of window openings, with both the provider's nominated individual and the service's management team during the inspection process. Shortly after the inspection we received a notification informing the commission of injuries one person had sustained falling from their ground floor bedroom window. This showed the service had failed to promptly address safety concerns raised during the inspection process.

In addition we found that risk assessment documentation had not been accurately completed and that accidents and incidents that had occurred within the service had not been consistently recorded. Where incidents were recorded they had not been appropriately investigated by managers to identify any trends or areas of increased risk within the service.

Recruitment practices at Menwinnion country house were safe and there were sufficient numbers of staff available to meet people care and support needs. However, staff had not received appropriate training or regular supervision from their managers. Staff told us the training they had received was, "Very hands on." In the five staff training records we examined only two staff had received safeguarding and first aid training while only three staff had received manual handling training. Staff had not received regular supervision in accordance with the provider's policies during their induction and none of the recently employed staff had

completed the Care Certificate training.

Managers and staff did not fully understand the requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards. Managers had correctly identified that one person's care plan was restrictive and had granted themselves an appropriate urgent authorisation. However, the service's managers had then failed to make the necessary application to the local authority.

The kitchen at Menwinnion Country House had received a five star food hygiene rating and people told us, "The food is excellent we have a good dinner every day." We observed that people were offered drinks and snacks throughout the day and that people were offered choices at all meal times.

People told us their care staff were, "Absolutely marvellous" and "The young girls are fun and the older ones are kind and lovely. The boys are wonderful." Throughout our inspection we observed that staff responded promptly to peoples' requests for support. A number of people chose to spend time near the service office laughing and joking with staff, the provider's nominated individual and managers. People told us their care staff respected their decisions and choices. One person said, "I am in charge, they do what I want them to do."

Where staff identified concerns about individuals well-being they took prompt appropriate action to ensure the person's care needs were met. People regularly received visits from external health and social care professionals and staff routinely sought guidance from professionals to ensure people's needs were met.

People's care plans did not accurately reflect their current care needs. One person did not have a detailed care plan while another person's had not been updated to reflect significant changes in the person's specific needs. None of the care plans we examined included information about the person's life history, background or interests. This meant staff were unaware of how people's background could affect their current care needs.

Before our inspection the service's activities coordinator had been covering for a staff vacancy in the laundry team. This had led to a decline in the amount of activities provided by the staff team. However, this vacancy had recently been filled and this had enabled the activities coordinator to support more activities within the home. On the first day of our inspection some people enjoyed a trip to a local tourist attraction while on the second day of our inspection an externally provided exercise class was held in one of the lounges. People told us, "They have entertainers who come in regularly" and, "I enjoy the scrabble on Monday afternoons."

At the time of our inspection there was no registered manager at Menwinnion Country House. The previous registered manager had recently taken on a new role for the provider and one of the service's existing deputy managers had applied to become registered. However, the service's current management team had not received appropriate support since the registered manager's departure. Managers were unaware of their responsibilities in relation to the supervision of new members of staff and had failed to make necessary deprivation of liberty applications as support requested from the provider's nominated individual had not been received. In addition, the provider's quality assurance processes were ineffective and had failed to identify the significant areas of concern identified in this report.

We identified breaches of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014. You can see what action we told the provider to take to address these breaches 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?

The service was not safe. Risk management procedures were not robust. Incidents and accidents had not been consistently recorded or appropriately investigated to identify areas of increased risk within the service.

Recruitment procedures were safe and staff understood both the providers and local authority's procedures for the reporting of suspected abuse.

There were sufficient staff available to meet people's care needs and there were appropriate procedures in place to support people with their medicines.

Requires Improvement ●

Is the service effective?

The service was not effective. Staff had not received necessary training and support to enable them to demonstrate they were sufficiently skilled to meet people's care needs.

Managers and staff did not fully understand the requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

Menwinnion Country House was well maintained and people's nutritional needs were met.

Requires Improvement ●

Is the service caring?

The service was caring. People got on well with their care staff and the service's management team.

People were comfortable requesting support from staff and staff responded promptly to people's requests.

People's privacy was respected and staff encouraged people to be as independent as possible.

Good ●

Is the service responsive?

The service was not responsive. People's care plans did not include sufficient accurate and detailed information to enable

Requires Improvement ●

staff to meet their care needs.

There were procedures in place for the management and investigation of any complaints received. Where complaints had been received these had been appropriately resolved.

There was a suitable programme of activities provided by both care staff and external facilitators.

Is the service well-led?

The service was not well led. There was no registered manager and the service's current management team did not fully understand the provider's policies and procedures.

Quality assurance systems were ineffective and had failed to identify the issues described within this report.

Requires Improvement 

Menwinnion Country House

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 checked 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 19 and 20 January 2015 and was unannounced. The inspection team consisted of one inspector.

The service was previously inspected on 16 October 2014 when it was found to be fully compliant with the regulations. Before the inspection we reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met and spoke with the nine people who used the service, four relatives who were visiting, eight members of care staff, the acting manager, the deputy manager, the provider's nominated individual and one of the provider's directors. We also spoke with three Health Professionals who visited the service during the inspection. In addition we observed staff supporting people throughout the home. We inspected a range of records. These included four care plans, five staff files, training records, staff duty rotas, meeting minutes and the services policies and procedures.

Is the service safe?

Our findings

The systems in place to manage risks at Menwinnion Country House were ineffective and did not adequately protect people. For example, one person's care plan stated that there were no window restrictors fitted to the windows in their room. Therefore the windows in their bedroom could be opened wide such that a person could fall through the opening. This room was on the first floor and there were two large unrestricted windows at seating level within the room. The person who lived in this room had become increasingly confused due to their dementia and no appropriate assessments had been completed on the risks posed by the unrestricted windows. We raised our concerns about the lack of appropriate restriction of window openings and adequate risk assessments with the provider's nominated individual and management team during our inspection. Shortly after our inspection we received a notification informing the commission of injuries another person had sustained falling from an unrestricted ground floor window. This demonstrated the service had failed to promptly address these concerns following our inspection.

In another person's care plan an assessment of risk in relation to falls had been completed. The most recent assessment had identified that the person had no history of falls. However, this information was inaccurate and records within the care plan demonstrated the person had fallen three times in 2015.

The service had correctly identified that one person with dementia was unable to leave the service without support from staff to ensure their safety. There were no locks on the service's doors and staff told us they ensured this person was safe by maintaining line of sight observations of the person's movements. This person's care records showed that these measures had not been sufficient to ensure the person's safety. One entry within the daily care records stated, "Quite unsettled this afternoon, very active. After supper found at top of the car park. Assisted back in doors and made warm." These incidents and others demonstrated that the current systems in place to ensure the safety of people living at Menwinnion Country House were not sufficient.

Accidents and incidents that had occurred had not been consistently documented, significant incidents recorded in daily care records had not been reported to managers and other incidents reported by managers and staff had not been appropriately documented. For example, one person's daily record said, "[Person's name] also became aggressive towards an other service user this evening which resulted in [person's name] pushing this resident and if care staff had not been present this resident would have been on the floor." This incident had not been reported to managers for further investigation. Where accident and incident reports had been completed these documents were stored on a clipboard in the manager's office. No analysis of these reported incidents had been completed. This failure to investigate reported incidents and the lack of consistent incident reporting meant managers were unable to identify areas of increased risk within the service.

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

However, though we found the issues we have described above in the systems of the service, people told us;

"I think we get incredibly well looked after", "Oh yes they are looking after me" and, "I feel safe here" while staff commented, "People are safe." Health and Social care professionals who visited the service regularly commented, "I do think people are safe here."

Staff understood their role in ensuring people were protected from all forms of abuse. Staff told us, "There are information leaflets about safeguarding in the staff room" and up to date information about local safeguarding procedures was available for all staff.

All lifting equipment within the home was in good condition and had been regularly serviced. All electrical equipment, water supplies and firefighting equipment had been regularly tested to help ensure their effective and safe operation.

The majority of the staff we spoke with told us they believed there were enough staff available to meet people's needs. Comments from these staff included, "We have enough staff, "I am actually a bit short of hours this week, I only have 24 when I should have 36" and, "I think there are ample staff." Some staff raised concerns about previous staffing levels on alternate weekends and overnight but commented that staffing levels had recently improved. One staff member told us, "With six of us on you can give the clients the time that they need". During our inspection we noted that the provider's nominated individual was in the process of reviewing the weekend staffing arrangements at the service. We reviewed the previous weeks staff rota and details of the numbers of staff employed by the service. Additional staff had recently been appointed and although there was some variation in the number of staff on duty each day we found there were sufficient staff available to meet peoples' care needs.

Staff recruitment practices at Menwinnion Country House were safe and robust. Necessary disclosure and barring service checks had been completed and people's references were reviewed before new members of staff were employed. Prospective staff had been interviewed by managers to assess their competence for their new role and people who lived at Menwinnion Country House had also been involved in the interview process.

People received their medicines safely, when they needed them. There was a dedicated room for the storage of medicines and appropriate systems were in place for the storage of medicines that required stricter controls. Where hand written addition had been made to people's Medicines Administration Record (MAR) these had been signed by two members of staff to confirm the information was accurate. Senior carers were responsible for the administration of medicines and we found most MAR charts had been appropriately completed. All issues raised during a recent Pharmacists audit had been resolved and on the second day of our inspection we saw a GP and Pharmacist visited the service to review people's medicines.

Menwinnion Country house was clean and one person told us, "The place is kept beautifully clean." Appropriate Personal Protective Equipment was available for staff to use throughout the service and cleaning materials were stored securely when not in use.

Is the service effective?

Our findings

Staff told us the training they received was, "Very hands on" but commented, "I have done a little bit of training" and, "You have to push for training." Staff had not received appropriate training in order to help demonstrate they had the necessary skills to meet people's care needs. We examined five staff files and found that in the three years before our inspection only two staff had received safeguarding training and first aid training while only three staff had received manual handling training. The systems in place to manage the training needs of the staff team were ineffective and did not accurately reflect the information recorded in individual staff files. For example, the training matrix showed only two staff had received recent safeguarding training. However, we found this training had been provided to two staff, one of whom had not been recorded as having completed this training on the training matrix. Managers had recently recognised that staff training needs had not been met. As a result a number of additional training courses had been arranged and during the first day of our inspection a Health and Safety course was provided to staff in one of the service's lounges.

Staff had not received necessary supervision or annual performance appraisals. Although some staff reported they had received individual supervision there were no records of recent staff supervision within any of the five staff files we examined.

The provider's policy was for all new members of staff to receive supervision from managers each month during their three month probationary period. The supervision records of recently appointed members of staff showed this supervision had not been provided. We discussed this issue with one of the service's managers who was unaware of this policy. Staff training records showed new members of staff had received limited formal training but did shadow experienced staff for a period before being permitted to provide care independently. None of the recently appointed staff had completed the care certificate training as part of their induction at Menwinnion Country House. The care certificate is a national qualification designed to give those new to working in the care sector a broad knowledge of good working practices.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some of the people living at Menwinnion Country House had a diagnosis of dementia. None of the care plans we inspected included any records of assessment completed by the service of people's capacity to make specific decisions or choices. We discussed the MCA with managers and staff who did not fully understand the requirements of the act. Although managers were able to provide examples of occasions

when they had made decisions in people's best interests these decisions had not been appropriately documented and people's capacity to make the specific decision had not been assessed. For example, the manager had recently made a best interest decision in relation to where medical equipment for one person was stored. The manager had decided that it was no longer safe for these items to be stored in the person's room and had made other appropriate arrangements for their storage. However, no assessment of the person's capacity in relation to this decision had been made and no records were kept of the decision making process.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and is legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although doors were not locked a Menwinnion Country House managers had correctly identified that one person was being appropriately restricted within the home in order to maintain their safety. The manager had granted themselves an appropriate urgent, seven day, authorisation to ensure the person's needs were met but had failed to make the necessary DoLS application to the local authority during the period of the urgent authorisation. This meant the person was being unlawfully detained.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people's care plans included limited information on how to support people if they became upset or anxious we observed during our inspection examples of staff effectively using appropriate techniques to support people. For example, one person became upset and wished to go outside during the first morning of our inspection. Staff provided the person with reassurance and support. Staff calmly escorted the person to the service's front door while effectively using distraction techniques to help the person relax. After a brief conversation with the staff member and other people seated at the service's entrance, the person decided to return to inside.

People told us their care staff arranged for doctors to visit if they were feeling unwell and one person said, "I had to have the GP visit yesterday." Another person's relative told us, "They were concerned about [my relative] so they called in a nutritionist and the doctor. It was all done quickly. They are on it." Health professionals spoke positively about the service's performance and told us, "They do follow any guidance we give them." In addition, we saw regular monthly meetings were planned between care staff and visiting district nurses to enable information to be shared and for staff to request specific guidance on how best to meet people's specific care needs.

People told us they enjoyed their meals and commented; "The food is very good for what it is, well cooked and interesting" and, "The food is excellent we have a good dinner every day." Staff said, "Everyone gets well fed" and we saw people were regularly offered drinks and snacks throughout the day. The service's kitchen had a five star food hygiene rating and the cook told us there was a rolling three week menu with two hot menu options available at lunchtime every day. In addition the cook told us, "People can always ask for anything they want." Information about people's specific preferences and dietary needs was available in the kitchen.

Menwinnion Country House was well decorated and appropriately maintained. Communal areas and bathrooms were clean and one person said, "It's lovely, home from home." People had personalised their own rooms with a variety of pictures, ornaments and furniture they had brought with them when they had moved in. One person's relative told us, "[My relative] wanted a shelf put up and it has appeared." Regular checks were completed to identify any areas of the building that required maintenance. Records showed

that where issues had been identified they were resolved promptly by the provider's maintenance team.

Is the service caring?

Our findings

Everyone we spoke with told us they were well cared for at Menwinnion Country House. People's comments included; "They really do look after us", "I love it here" and, "It's very good here." People's relatives said, "The staff are charming and very attentive" and, "They do sit and spend time with [my relative]."

People consistently complimented staff for their kindness and compassion. People told us their staff, "All have so much patience, I could not have done their job", "Are absolutely marvellous" and, "The young girls are fun and the older ones are kind and lovely. The boys are wonderful."

We spent time in the service's three lounge areas observing the care and support staff provided. People were clearly comfortable at Menwinnion Country House and got on well with their support staff. A number of people choose to spend time sitting near the manager's office and we observed managers and the nominated individual laughing and joking with people in this area. Staff told us; "It's important to spend that little bit of time with people", "The staff are really nice people there is a good atmosphere here" and, "I have a good relationship with people."

Throughout our inspection we observed that people approached staff for support without hesitation and people told us their staff always responded promptly to requests for support. Peoples' comments included, "They can be rushed at times but always stop if you need them", "They come when you need them" and, "If I ring my bell they come quickly."

Relatives told us they were, "Always made to feel welcome" at Menwinnion Country House and that, "Nothing is ever a problem." We saw staff supported people to maintain contact with their friends and relatives. Telephones were installed in some rooms and a cordless phone was available for people to receive calls. One relative told us the service was, "Very good at communicating with me" while another person's relative who visited every day told us the service also contacted other family members regularly to keep them up to date with any changes in their relative's condition.

We observed staff supporting people to mobilise using a number of different mobility aids. Staff were gentle and patiently encouraged and supported people to be as independent as possible. Where hoists were used to transfer people staff clearly explained how they intended to support the person and provided appropriate reassurance and encouragement during the transfer process.

People told us their care staff respected their decisions and that they were in control of how their care and support was provided. People's comments included; "I am in charge, they do what I want them to do", "I go to bed and get up when I want" and, "We do things in cooperation with the staff all together."

Staff demonstrated throughout our inspection clear concern for people's privacy and dignity. Staff knocked on doors and awaited a response before entering people's rooms, and ensured people were comfortable and their dignity respected while providing care and support. One staff member told us, "Everybody here speaks to people with dignity and respect. It can be very hard not to be patronising but you have to be

careful and remember people have had interesting lives."

One person's relative told us, "I think they handle end of life situations very well." The service worked effectively with health professionals to support people at the end of their lives and during our review of medicines we saw the service had arranged for end of life pain relief to be available in case one person's condition deteriorated suddenly.

Is the service responsive?

Our findings

People's care plans did not accurately reflect their current care and support needs. One person who had been living in the service for two months did not have a detailed care plan. When we initially reviewed this person's care plan it did not include any guidance for staff on how to meet their care needs. Later during the first day of the inspection we were provided with an updated version of this person's care plan. However, this document was of a generic nature and lacked detailed information for staff on how to meet the person's specific care needs. In another person's care plan staff were instructed to use inappropriate manual handling techniques while supporting the person to mobilise. However, we found that a third person's care plan had not been updated to reflect significant changes to the person's care needs.

Each of the care plans we reviewed included a section on "My life before you met me." In the majority of the care plans we inspected this section was blank and there was a noticeable absence of information about people's life history, background and interests in all of the care plans we inspected. This type of information is particularly important where services are caring for people living with dementia and other forms of memory loss. As this information can help staff to understand how the person's background and life experiences effects who they are today. The provider's nominated individual told us of some information they had recently received about one person's background that had helped to explain why their behaviour had changed during the festive season. However, this information had not been recorded within the person's care plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included records of the care and support they had received from staff. These records were detailed and included information on how the person had spent their day, details of the care they had received and information about any changes to the person's normal routines observed by staff.

There was an activities coordinator at Menwinnion Country House however, in the weeks before our inspection the activities coordinator had been working predominantly in the laundry to cover a vacancy. This had led to a decrease in the number of activities provided by the staff team. People had recognised this decrease in activities and one person commented, "There is not really much to do." While staff told us; "Everyone seems happy but I think some residents are bored so I am trying to come up with new things we can do" and, "They definitely need more activities, people are bored sometimes."

The provider had recently appointed a new member of domestic staff and a senior carer with experience of planning and delivering activities. This had resulted in an increase in the activities provided by staff within the home. During our inspection staff used the service's minibus to enable a group of people to visit a local tourist attraction. On their return people told us they had enjoyed their trip. In addition, on the second day of our inspection six people enjoyed an exercise class involving ball games in a lounge. Records were maintained of activities people had enjoyed and this information was used to identify future activities people were likely to enjoy. The weekly coffee morning was well attended and records showed musical

events with external performers occurred regularly. People told us, "they've got all sorts of games we can play", "I enjoy the scrabble on Monday afternoons", "I get the daily paper everyday" and, "they have entertainers who come in regularly."

People were able to bring their pets with them when they moved into Menwinnion Country House. On the first day of our inspection there was a cat and a dog living in the service and we saw one person walking their dog in the grounds during the second day of our inspection. In addition there was a well-stocked fish pond in the garden and one person had taken on responsibility for feeding the fish each day.

People were able to make choices and decisions in relation to both their care needs and the activities they engaged with. One person told us, "There are things on but I like to spend time on my own" and we observed that staff respected people's decisions and choices. People were free to move around the service as they wished and during our inspection some people chose to engage in activities while others preferred to spend time watching television or in the service's reception area watching wildlife in the gardens.

Menwinnion Country House had procedures in place for the management and investigation of any complaints received. The one minor complaint the service had recently received had been resolved to the complainant's satisfaction. People told us, "I can't honestly think of anything negative to say" and, "I can't complain at all, they are looking after me". While one relative said, "I have no complaints at all." In addition, we saw the service regularly received compliments and thank you cards from relatives and people who had received respite support. Recently received compliments included, "Thank you so much for the wonderful care you and your staff have given to [my relative]".

Where the nominated individual had recognised that the service was not able to meet people's increasing care needs they had appropriately requested support from health and social care professionals to meet the person's immediate care needs and identify a more appropriate service for the person to move to.

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager at Menwinnion Country House. The previously registered manager had recently accepted a new position providing training and support to the provider's other services. The provider's aim was for Menwinnion Country House to be led by a registered manager supported by two deputy managers. One of the service's deputy managers had been appointed to lead the service and was in the process of applying to become registered. In addition the service was in the process of advertising a deputy manager vacancy.

The provider's nominated individual worked from Menwinnion Country House three days per week and was well respected by the current management team. However, the management team had not received appropriate support since the registered manager's departure. Managers were unclear on their specific roles and responsibilities and were not aware of or did not understand many of the provider's policies and procedures. For example, the manager currently responsible for the training and supervision of new members of staff was unaware of the providers policies in relation to the support new staff should receive during their induction period. In addition managers were aware they needed to make a deprivation of liberty application to the local authority but as they were unclear on what this involved they had requested support from the provider's nominated individual. This support had not been provided and the necessary application had not been made within the required timescales.

The provider used a system of director's inspections to assess the service's performance. These inspections included a tour of the building and talking to people in receipt of care and support. However, these directors' inspections were not sufficiently robust to adequately monitor the services performance. These inspections had failed to identify the significant concerns in relation to risk management, staff training, staff supervision and the accuracy of care planning records identified earlier in this report.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was a lack of formal supervision staff told us their managers addressed and resolved any issues they reported. Staff comments included, "I think it is quite a good team", "Managers will help out when you need them" and, "I feel I can go to the manager about anything." One staff member told us, "I feel they listen and deal with things fairly, nothing is ever too much trouble."

People's feedback about the service's performance was valued by the provider. A survey had recently been completed and peoples' comments had been positive and complimentary. Residents meetings were held at Menwinnion Country house. The minutes of the most recent meeting in October 2015 showed that people's suggestions in relation to changes to the service's menu had been adopted.

People at Menwinnion Country House were happy and told us, "I would actually recommend them to anybody", "I don't think I could have done better than coming here" and, "I quite enjoy living here." One person's relative said, "If I had to come into a home in this area this would be the one for me." Most staff

were very positive about the service and the care it provided commenting, "It's amazing how good the staff are it's such a good company to work for." However, a minority of staff reported concerns about the services performance and told us, "It's a bit hit and miss."

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 9 HSCA RA Regulations 2014 Person-centred care The failure to provide staff with guidance on how to meet people's care needs represents a breach of regulation 9(3)(b).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent These failures in relation to the requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards represent a breach of regulation 11.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers failure to ensure risks were adequately managed and failure to record and investigate incidents is a breach of Regulation 12(1) as read with 12(2)(a),(b) and (d).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers failure to ensure there were appropriate systems in place to ensure compliance with the regulations is a breach of regulation 17(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The failure to provide staff with an appropriate induction, supervision and regular training is a breach of Regulation 18(1).</p>