Optimum Care (UK) Ltd

Ivy House

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 6 December 2016 and was unannounced. At our previous inspection during November 2013 the provider was meeting all the regulations we checked.

Ivy House is registered to provide residential care for up to 22 older people. At the time of this inspection some people were living with dementia. The service was providing support for 17 people at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the leadership and management of the service and its governance systems were not robust. Systems to monitor and review the quality of some areas of the service people received were not effective and therefore we found a number of areas that required improvement.

At this inspection we identified environmental risks for people who lived at Ivy House. These included an external door not being locked, which provided unauthorised access into the service. This also meant people who lacked road safety awareness due to their health condition, could leave the service without supervision. We saw that some furniture in the main dining lounge was damaged, which made it unsafe for people to use.

We identified shortfalls with the management of medicines. This included medicines not being stored securely. We saw the medicines fridge was not locked, as well as the cupboard where this was stored. This meant medicines could be accessed by unauthorised people who were not prescribed them.

Our observations showed that staff did not always respect people rights to make their own decisions when possible.

We observed a person carrying a walking frame whilst using the stairs. This showed that the level of risk had not been considered by the provider to avoid injury to the person and others including staff.

We saw staff were not suitably deployed. Our observations showed staff were not always present in communal areas which meant people did not always get the support they required. For example we saw one person pushing their zimmer frame into another person as they were frustrated with the other person's behaviour.

Recruitment procedures were not thorough. Staff recruitment records showed that a full employment history was not always in place.

We saw insufficient evidence regarding the training that staff had undertaken. The provider did not have effective systems to monitor training staff had undertaken or waiting to be completed, to enable them to do their job effectively.

Staff gained people's verbal consent before supporting them with any care tasks. However the provider did not have effective procedures for staff to follow in relation to the Mental Capacity Act (MCA) 2005. We saw that were people lacked capacity, mental capacity assessments had not been completed and staff had not undertaken training on the MCA

The needs of people living with dementia were not fully met because people's social and therapeutic needs were not addressed. People and their relatives were not always involved in planning and agreeing on how they were supported. This did not ensure people received personalised care.

People who used the service told us they felt safe. Staff we spoke with understood their responsibility in protecting people from the risk of harm. People told us that staff treated them in a caring way and respected their privacy and supported them to maintain their dignity.

People enjoyed the food and drink they were served. People were supported at mealtimes if they required this. Arrangements were made for people to see the GP and other healthcare professionals as and when they needed to.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Medicines were not kept securely to ensure they were not accessed by people who had not been prescribed the medicines. The deployment of staff was not always effective. People were at risk because the provider had not minimised all environmental risks, such as the key pad mechanism was not working on a door. Risks to people were not always minimised. People told us they felt safe living at the service. However safeguarding concerns were not always taking seriously and reported to the relevant agencies in a timely manner,

Is the service effective?

Requires Improvement

The service was not consistently effective.

Assessments were not in place to demonstrate that decisions were made in people's best interest when they lacked capacity to make decisions for themselves. Staff did not always respect peoples rights to make a decision when possible. Staff required further training to ensure people's needs were met effectively. People were referred to the relevant health care professionals when required, which promoted their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff were kind and affectionate towards people. Staff treated people with dignity and respect and were caring towards people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not receive individualised care. The social and therapeutic needs of people living with dementia were not being met appropriately. People and their relatives were not always in involved in the development and reviews of their care. People were confident that any concerns they raised would be listened

to and action would be taken.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems designed to check on the quality and safety of the service people received were not effective. The service had a registered manager in post; however they were not involved in the day to day management of the service. Staff and people that used the service were positive about the management of the home. People found the managers approachable.

Ivy 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 was planned to check whether the provider was 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 6 December 2016 and was unannounced. The inspection team included an inspector, an expert by experience (ExE) and a specialist professional advisor (SPA). An ExE is a person who has personal experience of using or caring for someone who uses this type of service. The SPA had a nurse background which included experience of dementia care.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. As part of our planning we reviewed the information in the PIR. We also reviewed the information we held about the service, which included notifications. Notifications are changes, events or incidents that the registered provider must inform CQC about.

We spoke with the local authority commissioning team. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with eight people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We also spoke with one relative, the registered manager, the deputy manager, one care staff and the activities care co-ordinator.

We reviewed records which included three people's care records to see how their care and treatment was planned and delivered. We reviewed three staff employment records and other records which related to the management of the service such as quality assurance, staff training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At this inspection visit we identified several environmental risks for people who lived at Ivy House. We saw that the window in a bedroom on the cottage side of the building on the ground floor had no window restrictor fitted. The window opened fully onto area which had debris such as pipes. We discussed this the deputy manager who told use they would address this. During the inspection we saw that the window restrictors had been fitted.

We found an external door located on the ground floor opposite room six was unlocked. The door opened onto a residential area and provided unauthorised access into the service. As well as people being able to leave the service, who lacked road safety awareness due to their health condition. We immediately raised this with the deputy manager who was not aware of this. The deputy manager looked at the door and told us they thought the keypad mechanism was not operating. We discussed the seriousness of this matter with the registered manager and deputy manager. Both managers told us they would take action to have the keypad mechanism repaired to ensure the door was locked securely. This did not provide assurance that the provider had taken steps to ensure people's safety and personal belongings were protected.

In the large dining room we saw that some dining furniture was damaged and appeared unsafe. For example the arm on one dining chair was damaged and splintered. Another dining chair frame was loose. We discussed this with the deputy manager who told us they would get these repaired. We also saw that some of the furniture in both communal areas was worn, which included the leather arm chairs.

We saw that staff were not always following procedures as specified by the provider. The kitchen door had a sign stating that it should be locked at all times. When we approached this area we saw that there were no staff in the kitchen, but the key had been left in the lock allowing access to the kitchen. We discussed this with the deputy manager who told us the kitchen door was always kept locked and expressed that the people at the service would not unlock the kitchen door.

During this inspection visit we identified some shortfalls with the management of medicines. Medicines were not always kept securely. The cupboard which stored the medicines fridge was not kept locked and there was no lock fitted to the medicines fridge. This did not provide assurance that unauthorised people would not be able to gain access to medicines which were not prescribed to them. The doors to the medicines storage area did not provide a secure barrier. The doors were single glazed and reinforced glass was not used. We saw that one person's eye drops were not dated to indicate the date they were opened. We also saw some people's topical creams had not been dated when opened. We found the medicines fridge contained some medicines which were no longer prescribed to anyone and had not been returned to the pharmacy.

We looked at the medicine administration records which had been completed accurately. The PIR stated there had been 20 medicines errors in the past 12 months. We spoke with the registered manager about this and they told us that they had taken action to address this issue. The registered manager told us medicines were administered by the managers or senior care staff. Training records confirmed staff had undertaken

training in this area.

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

People told us that they received their medicines from staff when they needed them. One person said, "Yes I think I get my medication on time. It's around the same time every day. Staff will ask if I need anything for pain and also at the moment they [staff] are putting cream on my legs. Another person said, "Medication isn't something you need to worry about. It comes on time and they usually offer me pain relief at the same time. I don't need to ask for it." We briefly observed staff administering people's medicines. We saw a person was given a drink of water and time to take their medicines whilst the staff member stayed with them to ensure the medicine had been taken.

During the inspection visit a person who used the service disclosed some information of concern to us. We shared this information with the registered manager and deputy manager who had been unaware of the allegation. They told us as the person was living with dementia and the allegation was not true. Following the inspection visit we reported the concerns to the local safeguarding team. On 20 December 2016 we received a notification from the service confirming that they had made a safeguarding referral to the local safeguarding team. This did not provide assurance that people who use the service were protected from the risk of abuse.

Staff we spoke with told us they had received training in protecting people from abuse. Staff were able to tell us the procedure they needed to follow if they suspected abuse was taking place. Staff told us if they had any concerns they would raise these with the deputy manager or the member of staff in charge

People told us they felt safe with the support provided by the staff at Ivy House. One person told us, "I feel very safe here. There is always someone round and about downstairs. When I am staying in my room, they come to check I am alright. I think they must also come and check in the night as well, as I sometimes hear the door." Another person said, "I feel very safe. You can always get a carer to come and help if you want one. I have got a buzzer in my room if I need it. A relative stated, "Yes I would say [name] is safe here. They look after [name] basic needs and has a nice bedroom. There is always someone on hand if needed. They now have a secure keypad system on the door so it's safer."

People's care records showed risk assessments were completed. Risk assessments related to people regarding their assessed needs such as moving and handling and nutrition. However the provider was not always managing risk to people's safety effectively. We saw a person who used the service carrying their zimmer frame whilst walking upstairs. We raised this with the deputy manager who told us the person had capacity and was aware of the risks associated to carrying the zimmer frame whilst using the stairs. We later observed the person carrying the zimmer frame again and on this occasion a staff member stood behind the person. This showed that the level of risk had not been considered to avoid injury to the person and others including staff.

We looked at staffing levels in the service. The majority of the people who used the service felt there were enough staff on duty to meet their needs. One person told us, "There are enough staff and they do respond in a timely manner. I never really have to wait for any length of time if I need help day or night." However a couple of people felt more staff were needed. A person said, I think they are sometimes short of staff as they have to do all sorts of things for people." A relative said, "I think at times there could be more as sometimes I only see a couple when I come and often residents are sitting on their own in the small lounge with no or little interaction or stimulation."

The deputy manager told us staffing levels were determined on the needs of people that used the service. Staff told us they felt staffing levels were fine and that there were enough staff to support people. A staff member said, "There are enough staff. Some days are busier and the deputy manager will help." Staff confirmed there were three staff on shift during the day and two waking staff through the night. We saw that staff were not always in communal area's to support people. For example we saw on a few occasions some people were getting frustrated with one person's behaviour. On one occasion a person was pushing their walking frame into the person. Whilst on a couple of occasions another person was shouting at the person to go away. This showed staff were not always suitably deployed, as staff were not always present in communal area's which meant people did not always get the support they required.

We looked at the recruitment records in place for three recently employed staff members. We saw that they had Disclosure and Barring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions. Two staff files seen had all the required documentation in place. However one staff file did not have a full employment history in place. This meant the provider was not always undertaking thorough recruitment checks to ensure staff were safe to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

The MCA 2005 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

We saw that staff were not effectively meeting the needs of people who were living with dementia. A person repeatedly asked to go to their bedroom so that they could rest. However staff and management were adamant the person did not go to their room until they had had their tea. We observed the person becoming agitated and pacing around the service. We discussed this with the managers who told us this had been agreed by the person's family. They also said if the person went to their room they would come back down after a couple of minutes. We saw no assessments confirming that this was the least restrictive option agreed in the person's best interest. This demonstrated that staff did not always respect people rights to make their own decisions when possible.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that capacity assessments had not been completed by the provider when people were thought to lack capacity. For example one person's care records stated the person was unable to make informed decisions that affected their life and well-being. We saw that there was no information regarding their capacity to consent in different areas of daily living. There was no detail on the specific level of support the person required to make decisions. Training records showed that staff had not undertaken training on the MCA and DoLS, which the deputy manager told us would be arranged with the training provider. Therefore the provider could not provide assurances that care and treatment was being provided in line with the principles of the MCA.

Our observations showed staff gained people's verbal consent before supporting them with care and support. A relative told us, "They [staff] always ask [name] before they do anything and check that [name] agrees."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS.

The provider understood when an application for a DoLS should be made and some people living at the service were assessed as being deprived of their liberty. At the time of our inspection two people had DoLS authorisations that had been approved by the supervisory body. The deputy manager told us they had submitted three applications for DoLS which had expired and were currently awaiting the outcome. A DoLS provides a process by which a provider must seek authorisation to restrict a person's freedoms for the

purposes of their care and treatment.

People we spoke with had confidence in the staff. They felt staff knew what they were doing and were knowledgeable about their care needs. A person said, "I think most of the staff here are knowledgeable but there seems to be some different ones lately. You can tell some of the new ones don't quite know what to do. But it's amazing what they all remember about each person and their care. Never ceases to surprise me that they don't have to keep asking." A relative said, "I think most staff are quite knowledgeable about [name] needs and what they like. If there are a lot of people around [name] doesn't know or is with certain people [name] gets upset. Staff do their best to accommodate [name]."

Records showed that staff had accessed a range of training. However the training record showed that not all staff had received the necessary training updates including infection control and safeguarding. The deputy manager told us that this had been arranged with the training provider and that any refresher training should be completed by March 2017. The deputy manager told us newly recruited staff received an induction within the service over a 12 week period. Staff we spoke with felt the training provided was relevant to their role.

The deputy manager told us formal supervision (a meeting with a manager to discuss any issues and receive feedback on a member of staff's performance) with care staff took place two to three times a year. The provider had a supervision planner which showed staff received supervisions. Staff confirmed they received regular supervision meetings and were able to discuss practice and development issues.

People were complimentary about the meal choice available and felt the food was good. A person said, "The liver and bacon was delicious. I could not have asked for better." We observed the lunch time meal; people who needed assistance were offered this. Staff were observed engaging with people throughout the meal. We saw that staff were patient whilst they offered people support and assisted people as required and at their own pace.

The deputy manager told us information on people's dietary needs was obtained when they moved to the service. Records showed people's nutritional needs were assessed. One person's nutritional assessment showed the person required assistance to eat their meal. Staff told us that they were aware of people's specialist dietary needs, likes, dislikes and nutritional needs.

Records showed that the staff liaised with health and social care professionals, including the GP as necessary. Staff confirmed that if they were concerned about people's health they would inform the manager on duty or staff member in charge. A person told us, "Never a problem if you need the doctor. They [staff] get them out quickly and make sure they let the family know as well." A relative said, "The staff get the GP out if needed and always let the family know if [name] is unwell or if there are any problems or changes in [name] wellbeing." This meant people had access to health care professionals and were supported to maintain their health.

The deputy manager told us each person had an 'emergency admissions pack', which contained a summary of people's needs. We looked at two peoples 'emergency admissions pack', they contained information on their medical history and care needs. The deputy manager told us 'emergency admissions packs' would be used when a person required an unplanned admission to hospital. The packs would provide the relevant professionals with background information regarding a person's health care needs.

Good

Is the service caring?

Our findings

Majority of people told us the staff at Ivy House were very caring and respectful towards them. One person said, "They treat me as a person which is very important when you are in my position. I don't want to be something they see to or look after because they have got to". Another person said, "The staff are all very caring and kind to me and I co-operate with those who treat me well. I like it here and accept it as it is. They make sure I am warm and comfortable." A relative told us, "Staff are caring but it varies from person to person and some are more patient than others. I think on the whole the care is task centred rather than person centred but having said that most of the staff do know [name] well."

Our observation of people's care showed that staff were caring and helpful. We saw staff approach people using the service with respect and in a kind and compassionate way. Staff interacted well with people whilst engaging in conversations with them. This demonstrated that people were treated in a respectful manner and received individualised care.

People told us staff treated them with respect. We observed people being treated with respect and their dignity was maintained. A person said, "Staff knock before they come in and respect your privacy. I wash and dress myself every day and I only have the occasional bath. It's my choice which they respect." Another person said, "I have a shower in the bathroom downstairs, as it's easier. The staff are always so cheerful and have a joke but treat you with respect. They make sure the door is closed and sit me on a chair and cover me up with a towel when helping me." Staff were able to explain how they supported people whilst respecting their privacy and dignity. We saw people were discretely prompted about their personal care needs. This demonstrated that people's privacy and dignity was respected and promoted.

Staff understood the importance of promoting people's independence. People told us staff supported them to maintain their independence. One person said, "The staff encourage me to do what I can for myself and make choices but are there to help if I am not well. A relative told us, "Staff prompt [name] with washing and dressing, rather than do it for her to help her remain independent. This demonstrated people were encouraged and supported to maintain their independence.

Most people were unable to say whether or not they were involved in setting up or their care plans. A person told us that their relatives had been involved in their care plans before they moved to the service. Despite this people told us they were happy with the care and felt their needs were being met.

People told us that they were supported to maintain relationships which were important to them. People living at the service told us staff were welcoming of their visitors. Relatives we spoke with also confirmed this. A relative said, "Staff make us welcome whenever we come and let us know what is going on both with how [name] is. And also if there are any events coming up we might want to come to as family such as barbecues." People told us there were no restrictions placed on visiting times. During our inspection we observed some people received visitors.

Requires Improvement

Is the service responsive?

Our findings

Some people told us the routines at the service were flexible and they were able to wake up and retire to bed as they wished. A person said, "I am very happy with everything. Like all places it has its ups and downs. Can be a bit noisy at times but quiet today. They all know me well and I get up and go to bed when I am ready."

The deputy manager and staff told us there was an activities co-ordinator employed who spent their time between this service and another service within the provider group. We saw most people spent the majority of their time, sitting in the lounges with limited social stimulation. We saw a few people were occupying themselves by carrying out activities they preferred. A person said, "I have a newspaper every day and I watch TV, sometimes in my room." However our observations showed people living with dementia were not provided with sufficient opportunities to ensure their needs were fully met. Our observations showed that there was little structure or stimulation to these people's daily lives. This did not provide assurance people received personalised care which met their individual needs.

We observed the meal time experience was not responsive to people's needs. One person said, "We have to have meals at time they say and you do sometimes have to wait a long time to be served. But it was exceptionally late today." At this inspection visit we saw that some people made their on way to the dining area up to 30 minutes prior to lunch being served. Some people were complaining to staff as they were hungry and were becoming restless waiting for lunch. We discussed this with the deputy manager who told us that, the provider had a catering system where ready prepared meals were purchased from a catering company. These were then reheated in a specialist oven and served by staff. It was not clear why there was a delay in the meal being served, as we were told by staff lunch was usually served by 1pm. This meant that consideration was not given to people's meal time experience.

The environment did not offer sufficient orientation and memory objects to support people living with dementia. These can be used to promote the wellbeing of people living with dementia as they can help to reduce confusion and support people's memory.

Care plans were not always person centred. Care records we looked at provided little information about how the person preferred to be supported. We did not see evidence that people's care needs had been reviewed.

People we spoke with told us they had not had to make a complaint about the care and support they received. One person said, "Quite happy and no grumbles at all about how they treat me or anything else." Another person stated, "I am not aware they have a procedure for complaining. I have never heard of anyone complaining. I think they do listen if you have anything to say about how things are. A relative told us their family had made a complaint which they felt was dealt with and sorted out satisfactorily.

Staff we spoke with knew how to respond to complaints. They told us if anyone raised a concern with them, they would share this with the registered manager or the deputy manager. A staff member said, "I would

listen and provide reassurance to the person and pass on their concerns to the mangers." We saw that there was a complaints policy in the service. The complaints record showed five complaints were received in the last 12 months, which had been addressed.

Requires Improvement

Is the service well-led?

Our findings

At this inspection visit we identified that the leadership and management of the service and its governance systems were not robust. We found that the provider did not always have organised systems in place for storing and retrieving information. For example during the inspection we found information was not easily accessible. This inevitably took up a disproportionate amount of our time when we requested information such as health and safety records.

We saw that there were 20 gaps in the recording of the medicines fridge temperature within a five week period. We discussed this with the deputy manager who stated that this was because the computerised system had gone down and not saved the information. The provider was using a computerised system and only had one laptop available at the service. Medicine competency records for two staff members were incomplete, which did not confirm their competency assessments in this area were up to date. We discussed this with the registered manager who stated all staff were up to date with their assessments, but the records had not been updated.

The provider did not have effective audit systems to ensure improvements could be made to service delivery. At this inspection visit we identified that medicines audits were not satisfactory, as the medicines fridge contained medicines which were no longer prescribed to people. The provider did not have systems in place to ensure the medicines room was regularly cleaned. For example we found that the medicines room was very cluttered and untidy. This demonstrated that continuous monitoring was not undertaken to identify where improvements were needed to enable the provider to address issues as identified.

There was no information that the provider undertook any analysis of incidents and accidents which had occurred. Therefore systems in learning from incidents to ensure that improvements to the quality and safety of the service provided were not effective.

The local authority carried out a health and safety visit to the service during September 2016 and November 2016 where they identified several environmental risks. We saw the provider had implemented an action plan to address the issues identified by the local authority. However at this inspection visit we found additional environmental risks to people such as there was no window restrictor fitted in a bedroom. When we raised this with the deputy manager, they told us that the local authority in their last visit did not identify this and that he would address this. We explained to the deputy manager that it was the responsibility of the registered person to ensure the building was safe. This demonstrated that the provider did not have effective systems in place to ensure that any environmental risks identified were reduced to ensure the safety of people who used the service.

We saw a risk assessment from an external fire management company dated October 2016 not all actions were completed. For example a break glass for a fire call point was not in place. We saw that this had not been replaced, which could cause the accidently activation of the alarm. The registered manager told us they were working to the timescales recommended by the external fire management company.

We saw a sample of health and safety records which showed the servicing of equipment was up to date. This included portable electrical appliance testing and gas servicing. Following the inspection the registered manager sent us fire bell testing logs, we found that there was approximately four weeks where the fire bells had not been tested.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the statement of purpose; A statement of purpose is a document which includes a standard required set of information about a service. The provider was providing care to people living with dementia. The deputy manager told us they would be changing their registration details with us to reflect these changes and to update the statement of purpose to reflect that the service was also providing care to people who were living with dementia.

People using the service knew the registered manager and the deputy manager. They told us they would be happy to talk to them about any issue. People raised no concerns about the running of the service. A person said, "I know who the registered manager is but have not seen her here for some time before today. The assistant manager runs the home on a day to day basis. He is very approachable and accessible and is a very caring young man who knows all the residents very well." A relative told us, "I know who is in charge here. I can't say I see the registered manager at this home much, but the deputy is usually here and is out and about in the home. There always seems to someone available to speak to if anything comes up when I visit."

The registered manager and the deputy manager, managed the running of the service. The registered manager told us about the future plans around the management of the service. They told us the deputy manager would be submitting a registration application to CQC and would be taking on the role of the registered manager. The deputy manager confirmed this. Staff we spoke with told us that the managers were approachable and supportive. Staff confirmed that meetings were held to inform them and provide an opportunity for staff to give their views and opinions.

People and their relative told us that their views about the service were sought through individual discussions and meetings to drive improvement. We saw that 'residents' meeting took place. One person said, "They have residents meeting and I think the staff do listen to what you say. Not only at these meetings but any concerns on day to day basis and do their best to put things right." A relative said, "I know they have resident meetings quite regularly and I think they do take note from what my family tell me." At this inspection visit some people told us that they were not able to have a cooked breakfast. The deputy manager told us they were aware of this, as it had been identified in a residents meeting. We were told by the deputy manager the provider had purchased a table top electric cooker, which would be up and running shortly. People we spoke with were unable to recall whether they had received satisfaction surveys to complete from the provider. However the deputy manager told us surveys had been given out to people and relatives during November 2016.

The provider was clear about their responsibility in notifying the CQC about incidents, events and changes that affect the health, safety and welfare of the people at the home and the running of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: People's safety was at risk because of environmental risks at the premises which had not been mitigated. The provider did not have effective arrangements in place to ensure medicines were stored safely. These were breaches of regulation 12 (2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider did not ensure that care and treatment provided to people was not restrictive and did not respect the rights of individuals. Regulation 13(4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the Regulation was not being met: The leadership and management of the service and its governance systems were not robust, which impacted on the quality and consistency of care

being provided and restricted the development of the service. The provider did not have a system to ensure themselves that the service they were providing was governed well and that they were meeting their obligations.

Regulation 17