Care UK Community Partnerships Limited

Whitby Dene

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

Overall summary

The inspection took place on 27 January 2015 and was unannounced.

Whitby Dene is a care home that provides accommodation and care for up to 60 people. The accommodation is divided over two floors. The ground floor accommodates 30 people who are living with the experience of dementia and the first floor accommodates 30 older people.

There was 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 and associated Regulations about how the service is run.

People living at the home and their relatives told us they were happy there and they felt they had their needs met. Some of the things people said were, ''I am very happy'', ''everything is fine, no complaints'', ''I am happy with everything'', ''the staff are kind, they don't fuss over you but are there if you need them.'' The staff also told us they felt well supported and happy working at the home.

Summary of findings

However, we found some areas of the service where people's needs were not being met and there were risks to their health and wellbeing.

During our inspection we observed some practices where people were put at risk because the staff were not supporting them in a safe way. For example, some people were supported to eat their lunch in a way which could have caused them to choke.

People were not always supported to take their medicines in a safe way. The staff who were responsible for managing medicines did not have the information they needed to make sure these were administered in a safe way. Records of medicines were not always accurate. Some people were prescribed medicines with side effects but the staff were not aware of these and they had not been risk assessed.

The provider had not always sought the consent of people to provide care and treatment. In some instances decisions had been made for people but there was no evidence to say how these decisions had been reached and if they were in the person's best interest.

Some of the interactions we observed were not caring or respectful. For example, people were supported to eat their lunch by staff who did not engage with them or show an interest in their enjoyment. We saw staff ignoring one person who asked them questions. We saw someone being touched by staff without them giving clear information or asking for their consent.

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

We also saw some positive interactions and staff acting with kindness. The staff we spoke with knew individual likes and preferences. There was a range of activities which reflected people's interests. Care plans recorded people's individual needs and their health needs had been assessed and were being met.

People were given a variety of freshly prepared food and their nutritional needs had been individually assessed.

The staff had a range of training and felt supported by the managers in the home. The provider undertook regular checks on the service and had an action plan where problems had been identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People were put at risk because the staff did not always care for them in a safe way. For example, people were at risk of choking because the staff did not support them appropriately when they ate.

People were not always given support to manage their medicines in a safe way. Some medicines records were incomplete, and staff did not have sufficient knowledge about the medicines they were administering to people, which may have placed people at risk.

There were enough staff employed and arrangements for recruiting staff were suitable. However, staff were not always deployed in a way which met people's needs and kept them safe.

Is the service effective?

Requires Improvement

The service was not always effective. People had not always given their consent to care and treatment. Sometimes decisions had been made on behalf of people but it was not always clear how the decision had been made in their best interest. The provider had not always acted in accordance with the legal requirements of the Mental Capacity Act 2005 to make sure people were not deprived of their liberty.

The staff felt supported and said they had the training and information they needed for their job.

People were given a varied, balanced diet and they liked the food. Their nutritional needs had been assessed and where people had an identified need this was met.

People had access to a range of health services and felt the service supported them to stay healthy.

Is the service caring?

Requires Improvement

The service was not always caring. We observed people being cared for in a way which did not always respect them or allow them to make choices.

However, we also observed positive interactions where the staff were kind, caring and respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive. People had care which reflected their individual needs, interests and choices. There was a range of activities and people felt their social needs were met.

People were aware of the complaints procedure and knew how to make complaints. The provider had responded appropriately to complaints.

Summary of findings

Is the service well-led?

The service was not always well-led. The provider had not always identified and managed the risks to people living at the home. There were quality monitoring processes and these were comprehensive, however we identified some concerns the provider had not.

People living at the home, their relatives and staff felt there was a positive culture at the home which was welcoming. They said the registered manager was visible and supportive.

Requires Improvement

Whitby Dene

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.

The inspection took place on 27 January 2015 and was unannounced.

The inspection team consisted of two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience on this inspection had personal experience and had worked with people living with dementia.

Before the inspection visit we looked at all the information we held on the provider. This included notifications they had made to us about accidents and incidents, safeguarding events and other significant events. We also looked at the last inspection report from 26 October 2013, when there had been no breaches of Regulations.

During the inspection visit we spoke with 15 people who lived at the home and eight of their relatives who were visiting the home. We also spoke with 16 members of staff, including the registered manager, activity co-ordinators, the chef, care staff and team leaders.

We used different methods to obtain information about the service. This included talking with people using the service and their relatives and meeting with staff. As some people were not able to contribute their views to this inspection, we carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the environment where people were being cared for. We looked at the way people were supported with their medicines, including how these were stored and recorded. We looked at care records for seven people living at the home and the staffing records for four members of staff. We also looked at how the provider monitored the quality of the service, including audits and checks, how accidents, incidents and complaints were recorded and minutes of meetings within the home.

Requires Improvement

Is the service safe?

Our findings

People were not always supported in a safe way. During the lunch on the day of our visit we saw staff supporting three different people to eat. One person was able to eat their meal independently, although they did this slowly. Their care plan stated they were able to eat independently. However, throughout a period of one and a half hours three different members of staff approached the person on different occasions taking their cutlery from them and putting food in the person's mouth. On one occasion a member of staff put four dessert spoons of food in the person's mouth before they realised the person was not swallowing. Another member of staff placed food in the person's mouth without looking at them. One member of staff also moved the person's head by pushing their neck and chin up on three occasions. Another person who had been eating independently was supported to have a drink by a member of staff. The staff held the back of the person's head whilst tilting the cup at an angle where they would have to drink or the drink would have spilt on their chin. The person was unable to move their head backwards or refuse the drink without it spilling on them. These practices put people at considerable risk of harm and may have resulted in them choking. None of the staff present in the dining room prevented these incidents.

The above evidence demonstrates that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not always given support to manage their medicines in a safe way.

We saw three instances where people were not receiving their medicines as prescribed. An antibacterial eye ointment for one person, prescribed to be applied three to four times a day, was being applied only once a day. One person had not received a prescribed food supplement for three days. Another person was prescribed two different eye drops. Because these were being administered at night, we noted that the person had refused these eye drops for nine out of the last 15 days, which meant that their condition was not being treated adequately. Staff told us that this person often refused their medicines. This had been recorded.

Some medicines records were incomplete or not up to date. Incomplete or inaccurate records increased the risk of medicines errors. The anticoagulant record book for two people had not been updated with their most recent blood test results and current anticoagulant dose. The instruction on their medicines record was "Take as directed in your yellow anticoagulant book". As the information in the anticoagulant record book was not up to date, this may have placed these people at risk of receiving an incorrect dose. The doses or frequency of administration of some medicines had been changed on some medicines records, and it was not clear who had authorised this change, and when. Some entries in the controlled drugs register were incomplete. Two people had allergies to medicines, but these were not recorded on their medicines administration records. Two people were self-administering some medicines, however this had not been risk-assessed, to check whether these people were able to do this safely. Records of application for some prescribed creams were incomplete or missing. Medicines for one person were being crushed before administration because the person did not have capacity and constantly refused to take their essential medicines. The appropriate approvals including consideration of their capacity, were in place to administer their medicines covertly in accordance with the Mental Capacity Act However, there was no evidence that the service had received confirmation from the GP or pharmacist that it was safe to crush these tablets.

When we looked at the prescribing of medicines for 21 people, we saw that eight of these people were prescribed medicines for dementia, and six people were prescribed regular daily doses of sedating medicines, such as benzodiazepines and antipsychotic medicines, for behaviour such as agitation or aggression. These were prescribed to be given on a regular basis, every day, instead of only when needed for agitation or aggression. Some people were prescribed combinations of these drugs, which meant that they were at high risk of falls. Staff we spoke with during the inspection, who were responsible for administering medicines and creating medicines care plans for people, did not know what these medicines were, what the risks were, and what monitoring was needed.

Regularly administered benzodiazepine medicines can cause drowsiness and unsteadiness, and may increase the risk of falls. Special monitoring is needed for people prescribed anti-psychotic medicines, as these can place people with dementia at risk of serious side effects, such as cerebrovascular events as well as increasing the risk of falls.

Requires Improvement

Is the service safe?

Medicines for dementia can place people at risk of side effects, such as nausea and vomiting. The staff were not aware of these potential side effects and therefore were not monitoring people appropriately.

There are good practice guidelines for the use of these medicines for people with dementia, such as the National Institute for Health and Care Excellence (NICE) and Alzheimer's Society guidelines, which staff at the service were not aware of. There was no evidence of regular and recent clinical reviews of these medicines involving specialists, no monitoring for side effects was being carried out, and no risk assessments were in place because of the increased risk of falls for people who were prescribed combinations of these medicines. Lack of knowledge about prescribed medicines may have placed people at risk of receiving these medicines inappropriately or excessively, and of not being reviewed regularly and monitored for potential side effects and risks.

The above evidence demonstrates that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some aspects of medicines management were safe, as we saw that all medicines, including controlled drugs, were stored safely, stocks of bulk medicines were counted regularly to check for correct administration, there was a robust system in place for ordering medicines for people, as all prescribed medicines were available, and records of administration provided evidence that the majority of people were receiving their medicines safely and as prescribed. Records were kept of medicines received, administered to people and disposed of, and for the majority of people, these provided evidence that people were receiving their medicines as prescribed.

One relative told us that on the day of the inspection a person who used the service nearly fell in a communal area. They said that staff were not available to support this person before or after the incident because they were in a meeting. They told us that no staff were available in these communal areas at the same time each day and they felt this put people at risk. We discussed this with the manager who agreed to make sure staff were available in communal areas at these times each day. We observed that during lunch, the member of staff administering medicines on the first floor occasionally stopped this to support people to eat their meals. This practice was potentially unsafe as the member of staff should have completed their medicines administration and stored the medicines trolley safely before attending to other tasks. The member of staff was not wearing a protective apron.

These incidents suggested that staff were not always deployed in a way to keep people safe and meet their needs.

People living at the home told us they felt safe living there. They felt the staff were employed in sufficient numbers. They told us call bells were answered promptly and staff were available when they needed them. However, one person and their relative told us they had not realised they had a call bell available in their bedroom.

The provider had policies and procedures for safeguarding adults. The staff had been trained in these. They told us they were aware of how to recognise and report abuse and gave us examples of types of abuse and told us they would speak with the manager, senior managers or the local authority. However, we observed two incidents where people were at risk of choking (reported above) as a result of the way they were being supported and the staff present did not recognise this as potential abuse.

The provider had assessed the risks within the environment. Each person's care file contained a clear and comprehensive assessment of risks for different aspects of care, including environmental risks, physical risks, risks in relation to people's behaviour and medical conditions. The assessments also contained details of ways to minimise or avoid each identified hazard or risk. Risks were reviewed on a regular basis.

There were effective recruitment and selection processes in place as staff personnel records showed they had been subject to appropriate and necessary checks prior to being employed by the service. This meant the provider had taken appropriate steps to make sure people were safe and their welfare needs were met by staff who were suitably qualified, skilled and experienced.

We looked at four staff files to check that information satisfied the relevant requirements. We saw that a copy of staff's proof of identity, their application form, which included their employment history were kept on file. We found people had been subject to checks with the Criminal Records Bureau, now carried out by the Disclosure and

Requires Improvement

Is the service safe?

Barring Service. We saw that references had been obtained to ensure people were of good characters and fit for work. Staff had undergone occupation health checks and their right to work in the UK was also clarified.

Requires Improvement

Is the service effective?

Our findings

The provider had not always made sure people had consented to their care and treatment.

We found that people or their representatives had not always signed their care plan and no indication was given how people were involved in making decisions regarding their care arrangements. We noted that this had been identified by the provider's own internal audit, however no action had been taken at the time of our inspection.

There were procedures for obtaining people's written consent, however these had not always been followed. For example, not everyone had signed consent for the use of their photograph. We saw that one person's relative signed a consent form to say the person could have a flu vaccination. However, there were no records about how this decision had been made and whether it had been made in the person's best interests. There was also no record of an assessment of the person's capacity to make this decision themselves.

The above evidence demonstrates that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were admission agreements signed by people or their representatives when a placement was funded privately. We looked at four of these records and found one was signed by the person and the other three by the person's representative. We were told that the relevant documents were seen to ensure the representative had the legal right to sign the document although only one Power of Attorney document was kept on file.

We found that one person's medicines were administered covertly and saw their GP completed the necessary mental capacity assessment and the best interest decision was recorded appropriately.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

One person was subject to the Deprivation of Liberty Safeguards which enabled the service to provide 24 hour care and supervision, help with personal care and medication and not to let them leave the home on their own. This decision had been made in accordance with legal requirements by the supervising body to restrict the person's liberty in their best interest.

Staff we spoke with understood the need to ask for people's consent prior to providing care. One member of staff told us "If somebody refuses something then we have to respect this." The staff said they had training regarding the Mental Capacity Act and Deprivation of Liberty Safeguards though this wasn't included in the staff training matrix.

People told us they felt the staff were well trained and skilled. One person said, ''they are good at helping us, they know what they are doing.'' A relative told us they thought the staff were able to care for people with dementia. They said, ''it's not always easy for them, but they are patient and seem to understand everyone's little ways.''

We looked at records of staff training and saw that they had completed an induction, followed by regular training in areas the provider considered mandatory, such as health and safety, medicines management and moving and handling. The provider's own audit identified that some staff needed to have training updates in specific areas. The manager told us this was planned and we saw memos for the staff reminding them to book places on this training. The staff also told us they had attended training in dementia awareness.

Staff comments included, "There's an excellent team spirit here", "managers are very supportive and staff as well", "team is nice and friendly" and "we're working together as a team.'' They spoke positively about the informal support from the manager and team. The staff told us the manager and deputy manager worked alongside them each day and were accessible for asking for advice and support. The staff told us they had not had an annual appraisal of their work. All the staff we spoke with told us they had regular supervision. Although records of staff supervision showed that not all staff had regular individual meetings with their manager. This had been identified in the provider's own audit as an area which required improvement. The manager was able to show us an action plan which stated that all staff would receive regular individual meetings and appraisals of their work.

Requires Improvement

Is the service effective?

Regular team meetings were held for the general staff, night staff, team leaders and head of departments separately. The minutes of these showed the staff discussed issues regarding people's care, accidents/incidents and health and safety.

The manager told us staff were enabled to obtain relevant further qualifications such as National Vocational Qualification (NVQ) Level 2 and/or 3 in health and social care which was confirmed by staff we spoke with.

People told us they liked the food and had enough to eat and drink. They said, ''I like the food'' and ''there is good variety and it is tasty''. The staff were able to tell us about how they needed to monitor people's nutrition and hydration. They told us they made regular checks to make sure there were drinks available in communal areas and bedrooms. We saw people were offered plenty to drink and encouraged to have regular drinks. Where people had not eaten much of their lunch time meal, they were offered alternatives. For example, one person told the staff they did not want their food. The staff offered the person something else but they still refused, so the staff member showed them different food options and made sure they had something they did like and wanted. Another person was offered a sandwich when they refused their main meal. The staff observed how much people ate and encouraged them to eat more. The chef visited the dining rooms at lunch time and spoke to people about their enjoyment, offering them different food if they wanted this. The chef told us that food was available for people throughout the day and night. The staff confirmed this, telling us they were able to make people sandwiches and hot food if they requested this outside of normal mealtimes. The staff told us they monitored if people had low appetite and made sure food was offered at regular intervals.

People's nutritional needs had been assessed and we saw evidence of this. Where people were identified at risk of malnutrition or they had a specific dietary need this was recorded and a care plan to meet their needs had been created. There were records of food and fluid intake for people who were identified at risk, we saw these were detailed and up to date. We spoke with the chef. She was aware of people's different dietary requirements and how to meet these. The catering team had received relevant training. The chef told us she met with everyone who moved to the home and their representatives to assess their food preferences and any particular needs. She also attended meetings for people at the home and their relatives to gain feedback on the food. She told us she visited the dining rooms each day and spoke directly to people for feedback and we saw this was the case on the day of our inspection.

People told us they had the support they needed to stay healthy. One person said, ''They look after me and if I get ill they call the doctor straight away.'' A relative confirmed that the staff monitored people's health and contacted healthcare professionals as needed. They said, ''The staff are very good at making sure (my relative) is well, if she has anything wrong they call me and the doctor straight away.'' People's healthcare needs had been assessed and there were care plans regarding specific health needs. The manager told us people were given a copy of their care plan to keep in their room and that any care plans around meeting health needs were explained. The care records we looked at contained information about appointments and the healthcare treatment people were receiving. These included information and guidance from the health professional. We saw these were incorporated into care plans.

Requires Improvement

Is the service caring?

Our findings

We observed some instances where the staff did not show people respect. For example, during lunch we saw staff supporting people to eat their meals. We observed four different people being offered support in two dining rooms. None of the staff sustained conversations with people and some of the staff supported people without speaking to them. The staff did not check people's enjoyment of the food. We saw staff supporting people by placing food in their mouths without looking at the person. Some of the staff looked around the room or talked with each other. We saw the staff approaching one person and wiping their mouth without warning the person or asking their permission on a number of occasions. One member of staff moved a person's chin and arm without speaking to them. The staff placed protective aprons on people without telling them what they were doing or asking their permission. During lunch one person was ignored by three different members of staff when they directly asked them a question. One person was supported by three different members of staff during their meal, without being told that the staff were changing over or why. Another person who was able to eat their lunch independently was assisted on four occasions by three different members of staff without being given a reason why they were doing this. On one of these occasions the staff member took the person's spoon, gave them some food and walked off. Two different people were supported by staff who were standing instead of sitting next to the person. One member of staff called two different people, ''mummy'' when speaking to them. We looked at the care plan for one of these people which stated the person liked to be called by their first name not ''mummy''.

One record we looked at referred to a person as ''it'' rather than using their name.

The above evidence demonstrates that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no menus or pictures of menus on display so people did not know what food they were being offered. People were able to choose from a number of options the day before but some people we spoke with could not remember the choice they had made. In one dining room people were offered a choice when they were served and some people were shown two different options on a plate to help them make a decision.

People living at the home told us the staff were kind and caring. Some of the things they said were, ''I think the staff are very hardworking", ''it is a happy place''and ''Everyone is very friendly.'' With the exception of the concerns we identified during our lunch time observations, we observed positive and friendly communication throughout the rest of our visit. The staff had a good understanding of people's likes and preferences and took time listening to the things people said. Relatives of people told us there was good communication between the staff and themselves, letting them know if anything was wrong or they needed anything. The staff spoke with genuine fondness about people they were caring for. One member of staff said, ''We care for them like they are our family, they deserve to have good care.'' We saw some examples where the staff responded promptly to offer support and comfort, for example when one person spilt a drink on themselves and when another person was confused and appeared lost.

People looked well cared for and clean. Everyone was in clean clothes and their hair and nails had been attended to. The staff responded promptly when one person needed their clothes changed. The staff attended to people's needs discretely, knocking on doors and making sure doors were closed before they offered care. When people were supported to move from chairs to wheelchairs, the staff explained what they were doing and offered the person comfort and support.

People told us they were asked their opinion about arrangements at the home. For example they said they were able to make suggestions for group activities and menu options. There was evidence that the provider held regular meetings for people living at the home and their relatives, to keep them informed of changes and ask for their opinions. There were notice boards with a variety of information and the manager told us he was in the process of making a photographic board of all the staff. However, this was not in place at the time of our inspection and some people we spoke with did not know who the staff who cared for them were.

Requires Improvement

Is the service caring?

People's cultural and religious needs had been recorded. The manager told us that regular church services were held at the home, and one took place on the day of our visit. The chef told us that she was aware of people's different cultural and dietary needs and these were catered for.

Good

Is the service responsive?

Our findings

People told us they received care which met their individual needs. They said the staff were aware of their preferences and these were reflected in the care they were given. The building had been decorated and furnished with features to offer sensory interaction. There was a sensory room, and features in the corridors and communal areas such as different textures, paintings and a board people could draw and write on. There was also a reminiscence lounge where people could relax amongst furniture, ornaments and pictures from the past.

People's individual needs had been assessed and recorded in care plans. These were regularly updated. Care plans included information on things people could do independently. They were personalised and gave staff clear instructions about how to meet people's physical, health, personal and social needs. Risk assessments were completed regarding any identified risks, for example falls, fire and behaviour. These included control measures and action plans to avoid or manage the risks in order to ensure people's safety. Staff told us the care plans were evaluated on a monthly basis. Daily records were kept electronically and these showed that people's care was given as planned. Some people had detailed documents about their life before they moved to the home. Where these were in place they personalised care plans and gave staff more information about what the person liked and who they were.

There were two activity coordinators employed to work at the home. They organised and ran a number of group and individual activities. We saw people were supported to take part in a range of different activities and were able to access games and other resources. People told us they liked the activities and there were things for them to do. There were regular outings to the shops and places of interest. The weekly plan of activities was displayed on a notice board. The provider also had a shop at the service, which people living at the home were involved in running. This provided toiletries and snacks for people who did not want to or were unable to leave the home to shop in the community. The activities coordinators spoke positively about their role. One told us,

"I love it", "my job is the best job in the house, I get a very good reaction from people" and "I do try to spend time with new people to get to know them". They also told us care staff supported with activities saying, "I do get support from staff." They told us they read care plans and risk assessments and spoke with care staff before planning new activities or supporting new people.

There were monthly meetings for people who lived at the home to give their views about the types of activities they wanted.

There was an appropriate complaints procedure and people had been given a copy of this. They told us they knew what to do if they had a complaint. People felt the manager listened to and acted on their concerns. One relative told us they had made a complaint to the management about a year ago but said this had been dealt with satisfactorily. People told us they had ''no complaints'' but if they did they would speak to staff about them. The staff told us they had confidence in the management that it would be dealt with, if they had to report a concern. We looked at the provider's record of complaints. There was evidence these had been investigated and responded to appropriately. We also saw the provider had learnt from complaints. For example, one person had complained about the way their relative's change in health had been communicated. The provider had made alterations to the procedures at the home to make sure staff notified relatives promptly in these circumstances.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we identified concerns about people's safety and wellbeing, including how people's medicines were managed. We also found that the provider had not always acted within legal requirements to obtain people's consent to their care and treatment. Therefore they had not always identified and managed the risks relating to the health, safety and welfare of people living at the home.

This demonstrates that there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider undertook a range of audits and these included checks by senior managers within the organisation. The most recent one of these had taken place on 6 January 2015 and had considered whether the service was safe, effective, caring, responsive and well-led. The provider had made a number of recommendations where they had identified problems. The manager had created an action plan which was shared with senior managers to state how and when improvements would be made.

There were also checks on the environment, records and the care people received made by the manager and leadership team of the home. These were recorded and we saw that they were discussed at team leader meetings. Where problems had been identified there were action plans for improvements.

People who lived at the home told us they thought there was a positive and friendly atmosphere. Some of the things people said were, ''it is a very happy home'' and ''we feel well cared for and supported.'' They said they thought the service was well-led. The staff felt well supported and told us the manager was visible and available. They also told us senior managers visited the home and they could access support via the organisation's internal on line systems. Many of the staff had worked at the home for several years and they said they liked working there and that the culture was ''fair and open.'' They told us that the manager had introduced changes and these were for the better.

The provider worked with other agencies and professionals to improve the service at the home. For example, the service had links with a local mental health service for older people, who had provided advice and training for staff as well as assessing individual people's needs. There was evidence that the provider consulted a range of different good practice guidance and he had shared this information with staff through team meetings and memos.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each service user was protected against the risks of care and treatment which was inappropriate or unsafe because they had failed to deliver care that ensured the welfare and safety of each service user.** **Regulation 9(1)(b)(ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not protected service users against the risks associated with the unsafe use and management of medicines.** **Regulation 13(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person had not made suitable arrangements for obtaining and acting in accordance with the consent of service users.** **Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not protected service users against the risks of inappropriate and unsafe care and treatment because they had not identified, assessed and managed the risks relating to the health, safety and welfare of service users. Regulation 10(1)(b)
	The registered person had not made suitable arrangements to ensure service users were treated with consideration and respect. Regulation 17(2)(a)