Veecare Ltd

High Meadow Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 and 8 January 2016 and was unannounced. At the previous inspection on 17 May 2014, we found there were no breaches of legal requirements.

High Meadow Nursing Home provides accommodation with personal and nursing care for up to 34 older people, some of whom are living with dementia. There are 28 single rooms at the home and 27 people were living at the home at the time of inspection. The accommodation is over three floors and bedrooms can be accessed by a passenger lift. People share a communal lounge/dining room and a conservatory. There is an accessible and secure garden to the rear of home. This contained a summer house, which had been turned into a tea room for people to use in the warmer weather.

The service has a registered manager who was available and supported us during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Medicines were stored safely and administered by qualified nurses. However, there was not always clear guidance in place for them to follow to ensure they gave people medicines prescribed to be given 'as required' appropriately and consistently.

Although people's personal care needs were met, there were not sufficient numbers of staff available to interact with people so they received stimulation and emotional support. Information had been gained about people's likes, preferences and past history. However, this information was not effectively used to plan and deliver an individual and group activities programme. An activities coordinator was available for six hours a day. Staff did not have time to sit and talk to people, but chatted to them about their interests and families when supporting them with their personal care. External entertainers visited and special occasions were celebrated such as people's birthdays.

Quality assurance systems were in place, but where shortfalls had been identified the action taken to address them had not always been reviewed to ensure that it was effective.

Checks were carried out on all staff at the home, to ensure that they were fit and suitable for their role. Staffing levels ensured that people's physical and personal care needs were met, but were insufficient to meet people's social needs.

Assessments of risks to people's safety and welfare had been carried out and action taken to minimise their occurrence, to help keep people safe. Health and safety checks were effective in ensuring that the environment was safe and that equipment was in good working order. Staff knew how to follow the home's safeguarding policy in order to help people keep safe. Accidents and incidents were monitored.

People had their health care, nutritional and fluid needs assessed and monitored and professional advice was sought as appropriate. People were offered a choice at mealtimes, and where appropriate support was provided and people were not rushed.

New staff received an induction which included shadowing new staff. Staff were provided with training in the areas necessary for their role, and this was refreshed on a regular basis. All staff had received training in the Mental Capacity Act 2005 and staff understood the principles of the Act and how to apply them. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. DoLS applications had been made for people who lived in the home to ensure that people were not deprived of their liberty unnecessarily.

The environment had been adapted for people living with dementia and people had memory boxes with information and photographs that were important to them. However, these boxes were not accessed on a regular basis.

People's care, treatment and support needs were assessed before they moved to the home and a plan of care developed to guide staff on how to effectively support people's individual needs. Clear guidelines were in place for staff to follow for people who became anxious or distressed or whose behaviours may challenge themselves or other people.

The views of people and their relatives about the quality of care provided at the home were regularly sought. Relatives felt able to approach the registered manager or staff if they wished to discuss a concern. The service had received a number of compliments.

The registered manager was a visible presence in the home and led a staff team who were clear about the aims and values of the service. Relatives said they would or had recommended the service to other people.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not clear guidance in place for nursing staff to follow when people had been prescribed medicines to be given 'as and when required'.
Checks were carried out on staff before they started to work at the home but there were not sufficient numbers of staff available to meet people's social and emotional needs.
Risks to people's safety were assessed and effectively monitored.

Staff knew how to recognise any potential abuse and so help keep people safe.

The home was clean and procedures were in place to minimise any infection.

Is the service effective?

Good

The service was effective.

Staff had the training they required to support the people in their care and had a sound understanding of the principles of the Mental Capacity Act 2005 to ensure that people's best interests were always promoted.

People's health care needs were assessed and monitored and they had access to healthcare professionals when needed.

People's dietary needs were assessed and monitored. Meal times were managed effectively to make sure that people had an enjoyable experience.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

People were involved in decisions about their care.

People's preferences about their end of life care had been recorded and these were acted on.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed before they moved to the home and staff were provided with clear guidance so they knew how to support them.

People were not always provided with a range of suitable one to one and group activities that met their needs and preferences.

People and relatives knew how to raise a concern or complaint and felt listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led

Quality assurance and monitoring systems did not ensure that all shortfalls were identified or where shortfalls had been identified, that the action taken to address them was effective in improving the service.

The registered manager was clear about the vision and values of the service, which they effectively communicated to the staff team.

Staff, people and their visitors were provided with forums where they could share their views and concerns and be involved in developing the service.

High Meadow Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 6 and 8 January 2016 and was unannounced. The inspector was joined by a specialist nurse adviser on the second day of the inspection.

We did not send the service 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. However, we looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

We spoke to ten people who lived at home and ten relatives. We spent time in the lounge, observing how staff interacted with people and joined some people for lunch. We spoke to the registered manager, deputy manager, one nurse, a senior carer, four care staff, the chef and the maintenance/housekeeper. We received feedback from four health care professionals, one social care professional and a visiting hairdresser.

During the inspection we viewed a number of records. We looked at the care notes in relation to six people and spoke to four of these people and/or their relative, and staff, to track how people's care was planned and delivered. We viewed the Mental Capacity Act 2005, medicines and infection control procedures. We also looked at other records including the recruitment records of the five most recent staff employed at the service; the staff training and induction programme; staff rota; administration and storage of medicines, complaints and complements, staff and residents meetings, menu, health and safety and quality audits, questionnaire surveys and the statement of purpose. The statement of purpose is a document which sets

out the aims and objectives of the service and the types of people whom the service can provide care for.

Requires Improvement

Is the service safe?

Our findings

Relatives and visitors said that people were looked after safely. They said that they did not worry about their friend or relative when they left the home, as they knew they were in safe hands. "I am here all the time", one visitor told us, "I would see anything if it was not right". Another person told us, "Staff are fabulous. They are friendly and welcoming. It is like that every time that I visit". Visitors said that staff were always very busy, but they attended to peoples' personal and health needs.

The medicines policy stated that there should be a clear protocol in place for people who were prescribed their medicines to be given 'as required' (PRN). However, these instructions were not always clear and easily available to nursing staff. One person experienced seizures. Their care plan stated that if their seizure occurred for more than five minutes, an ambulance should be called, but the guidance on the medical administration record was that a specific prescribed medication should be given in this situation. There was no guidance in place about what action to do if the seizure continued after the administration of this medicine.

One person had diabetes and their blood sugar levels were monitored regularly. Guidance had been obtained from the diabetes nurse about what action nursing staff should take if the person's blood sugar was low. This included giving the person a sugary drink or specific medication. However, there was no protocol in place for when this specific medication should be used. We asked a nurse when they would administer this specialised medication. The nurse said when the person's blood sugar was at a specific level. However, when checking this person's records, we found that other nursing staff were not administering this medicine when their blood sugar level fell to this level. When the medication had been given only one dose had been given, when the guidance from the diabetic nurse was to give two doses. Therefore, due to a lack of protocol in place for this medication, staff were administering it incorrectly and inconsistently.

The lack of clear protocols in place for medicines to be given as when required is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's staffing needs were assessed when they moved to the home. There was one nurse on duty at all times and six care staff were available between 8am to 2pm and four care staff until 8pm. At night there were two care staff and staff said this was sufficient. The registered manager said that each person had one hour's personal care support from staff each day. Staff said they were very busy. They said they had time to attend to people's personal and physical care needs, but did not have time to sit and talk to people. Staff were busy on the days of our inspection: they did not rush people, but they did not have time to sit with people or engage them in conversation. There was an activities coordinator employed six hours a day, but they were on leave on the two days of our inspection. On the first day, people in the lounge were un-stimulated for most of the day, with only a short game of ball taking place and people went to sleep. Therefore, there were insufficient staff to meet people's social and emotional needs.

The lack of sufficient staff available to meet people's social and emotional needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as their risk of falling, risks when people were moving around their home and of developing pressure areas. Guidance about any action staff needed to take to make sure people were protected from harm was included in the risk assessments. For people who were at risk of falling, the staff support and/or equipment they needed to remain safe, was identified. This included the use of a walking frame, hoist or pressure alert pad, to inform staff when people were mobile at night time. Staff walked with some people when mobilising with a frame and kept a close eye on other people to ensure they were safe. All transfers of people using equipment in the lounge were safely and appropriately carried out. Where people had developed pressure ulcers, the area had been measured, a photograph taken, dressings had been applied and each wound monitored and evaluated.

Regular checks were made of the environment to make sure that it was safe. This included visual checks of each room to make sure they were free from obstructions and that water was at a safe temperature for washing and bathing. There were procedures in place to make sure that equipment such as fire-fighting equipment, beds and mattresses, gas and electricity supply, and hoists were checked and regularly maintained.

Staff knew to report any accidents or incidents. These were reported together with any action taken as a result to keep people safe. The registered manager reviewed any incidents to see if there were any patterns or trends and to learn from any mistakes. The provider checked this audit at their monthly visits. The service had a continuity plan in place which set out how the service would continue to support people in the event of an unexpected event or disaster, such as a gas leak or flood.
Staff demonstrated they understood how to recognise different forms of abuse and said that any change in a person's behaviour or manner would be a trigger for them to speak to the nurse on duty for this to be investigated further. Information about how to raise a safeguarding concern to the local authority was available to staff and visitors so there would be no delay in making a referral if necessary.

The recruitment of new staff followed a set procedure and a checklist was in place to ensure that all appropriate checks were carried out before staff started to support people in the service. Staff completed an application form which asked them about their skills and experience and past employment history, including any gaps in their employment. Applicants attended an interview to assess their suitability and if they were successful identification checks, right to work in the UK, a Disclosure and Barring Service (DBS) check were undertaken and two references were requested. A DBS identifies if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Medicines were administered by nursing staff only. The clinical room where medicines were kept was well organised and kept securely in locked cupboards. Suitable facilities were available for storing controlled drugs and those which required refrigeration. Most medicines were contained in a monitored dosage system. This is a method whereby the dispensing pharmacist provides each person's medicines in separate compartments of a blister pack. Some medicines were kept in their original packages and containers and these were clearly labelled and kept separately for each person so they could easily be accessed. There were no gaps in the medication administration record (MAR), showing that people had received their medicines as prescribed.

A housekeeper was responsible for ensuring that the home was clean and free from infection. Cleaning staff were given specific tasks to carry out each day to make sure the home was clean and free from any unpleasant odours. Personal protective equipment and hand-washing facilities were available for all staff. The laundry room and sluice floors had been renewed to ensure that they were water proof. Staff knew how to deal with soiled laundry to minimise the spread of any infection.

Good

Is the service effective?

Our findings

Relatives said that staff were effective in informing them and taking action when there were any changes in people's health. One person told us that when their relative got very anxious, the doctor was contacted and health checks undertaken to see if there was any physical cause. Another person told us, "The staff are very good. They are always popping in and the nurse comes and makes some checks. When I was concerned about my relative not being well, the nurse came straight away".

A health care professional, who had visited the home for a number of years, told us the nursing staff team were consistent and knew people well. They said nursing staff contacted them for support in a timely and appropriate manner and the advice they gave was always followed.

People's care plans gave staff written guidance about people's health needs and medical history. These included information about people's medical conditions and what support they required from staff and other professionals to maintain their well-being. People's health care needs were regularly reviewed and nurses undertook regular checks on people to monitor their health. Referrals had been made to other health professionals as appropriate such as the diabetes nurse, dietician and psychiatrist. Nurses were proactive in taking action if there had been a delay in seeing a professional from the time of the referral. This helped to ensure that people received the professional support and guidance they required. When people attended a health care appointment, a record was made of the visit, together with any guidance that was given and people's care plans were updated accordingly.

Where people may present behaviour that challenges themselves or others, a plan of care was in place. This identified the nature of the behaviour, the potential triggers for the behaviour and guidance for staff on the appropriate action to take to minimise the occurrence. A visitor told us their relative could present behaviours that were challenging to others. They said staff were "fabulous" in the way they had supported this person. The registered manager had discussed the concerns with them and they had worked together to promote this person's physical health and well-being.

People's need in relation to food and fluids were assessed and the support they required was detailed in their plan of care. People's weights were taken monthly, to monitor any changes. When there had been concerns about people losing weight, food and fluid charts were put in place to closely monitor how much people ate and drank each day. The amount of fluids people drank were added up each day by the nurse on duty, to ensure that people had had enough to drink. Concerns about people's weight loss were discussed and food supplements were obtained and referrals made to the dietician.

People said they were offered a choice at mealtimes and that they enjoyed their meals. Relatives said the food offered to people always looked good. At lunchtime people were offered a selection of drinks and so involved in decisions about what they ate. Mealtimes were not rushed and people were able to eat at their own pace. Where people required staff support to eat, staff sat next to the person so they were at the same level to support them and engage them in conversation.

New staff completed an in-house induction which included gaining knowledge about the home's policies, safeguarding, communication and dementia. They also completed a work book covering the standards recommended by Skills for Care Common Induction Standards (CIS). The CIS were updated in April 2015 to a new Care Certificate, and the registered manager had obtained information about this. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised. Staff completed mostly on-line training during their induction period and shadowed more senior staff until they were signed off as competent.

There was an ongoing programme of training for staff in health and safety, fire awareness, infection control, emergency first aid, safeguarding and food hygiene. This training was completed by staff on-line and then staff completed work books to check their knowledge. Staff received practical moving and handling training from one of the providers. Specialist training had been provided to staff in supporting people with behaviours that challenge and dementia. Most staff had completed Diploma/Qualification and Credit Framework (QCF) levels two or above in Health and Social Care. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in the best interests and as least restrictive as possible. Staff had a clear understanding of MCA principles and how to put them into practice. They gained consent from people before supporting them with any tasks. Staff told us that a lot of people were living with dementia. They said their capacity to make day to day decisions fluctuated and explained how they supported people in their best interest. Staff knew that if people were assessed as not being able to make an important decision that an advocate could be appointed and a meeting held to ensure a decision was made in their best interests. An advocate can help people express their needs and wishes and weigh up and take decisions bout the options available to them.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Applications had been applied to a 'supervisory body' to be considered and checked to ensure that the service was acting lawfully.

Staff said that they felt well supported by one another, and many had worked at the home for a number of years. Staff said they could approach the nurse on duty or registered manager to discuss any issues or concerns. Staff meetings were regularly held for care, nursing and domestic staff. The registered manager conducted formal supervisions and annual appraisals with all staff. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

The needs of people living with dementia had been considered in the design of the home. People had their name and a picture on their bedroom door of something that had meaning to them, so it was easier to recognise their own room. On the wall, most people had a visual display of items they were interested in, which reflected their personality. For example, one person had a pint of Guinness and another message that they were the 'Best Mum!' In the lounge there was a sweet shop, where people with access to their own money and relatives could buy sweets they remembered from their childhood. In the garden a summer house was being developed, with the help of relatives, into a tea room, to use in the summer.

Good

Is the service caring?

Our findings

People told us that the staff gave them good support and that they were caring. "The staff are good. I cannot fault them", one person told us. Relatives said that staff were friendly, kind and understanding. "I would recommend the home as it has a lovely atmosphere and the staff are always friendly and approachable", one relative told us.

Everyone told us that people were treated with dignity and respect. Treating people with dignity was one of the values of the home and staff knew how to put this into practice. There was a dignity tree on the wall, which people saw as soon as they entered the home. The registered manager and two other members of staff were dignity champions. A dignity champion challenges poor care practice, acts as a role model and educates and informs staff working with them.

Relatives said they and their relative were consulted about decisions in their care. One visitor told us that it had been suggested their relative might like to move to a different room which was brighter and may help alleviate their low mood. This had been fully discussed with the person and their relative before the move was made.

Staff showed concern for people's well-being in a caring and meaningful way and responded to people's needs. For example, one person was living with dementia and repeatedly informed staff they had not had anything to eat. Staff were patient in acknowledging this person's concerns and explaining in a calm manner that they had eaten breakfast. This person was offered some additional toast. At lunchtime staff checked with this person they had had enough to eat and they responded that they had.

Staff said that a large number of people were living with dementia and understood that people had different types of dementia. Staff stressed that the most important way to communicate with people was not in relation to their diagnosis, but to adjust to the individual and their personal needs and preferences. A relative told us, "Staff understand about dementia. When my relative says 'yes' they may really mean 'no'. Staff demonstrated that they knew who enjoyed and understood how to have a joke and exchanging witty comments with them, and who preferred and understood a more straightforward conversation.

Staff listened to people and talked to them in an appropriate way so they could understand. We could not understand everything that one person said to us and asked a member of staff to explain what this person was saying. The staff member knew immediately what the person was asking for. The staff member explained that this person liked a daily set routine and they reassured them that the next part of their routine would take place after breakfast.

Staff checked people's comfort throughout the day. For example, when one person sat down in the lounge, they asked the person if they were warm enough and whether they wanted their cardigan done up.

Detailed information had been obtained for each person about their past history and what they liked to do.

Some of this information was kept in people's care plans and some in a memory box, together with photographs. Staff said they did not access the memory boxes, but got to know about people's preferences and past lives through conversation whilst supporting people with their personal care. Staff said these conversations were two way, as people often liked them to hear about staff's own families. A relative told us, "Staff asked about my relative's personality on the day they moved here and they were genuinely interested in learning more about them".

People's preferences and choices about how they wanted to be supported at the end of their life were clearly recorded. There was a check list to ensure that when people were at the end of their life, that these wishes and choices were acted upon. The service accessed support from specialist palliative care professionals when required. One person had been activity involved in the development and maintenance of the garden. Their contribution was valued by a plaque of remembrance which was visible as soon as people stepped into the garden.

Requires Improvement

Is the service responsive?

Our findings

People said that staff were responsive to their needs. One person told us, "Staff come when I need them to help with my personal care needs". Another person told us, "Yes, staff came straight away last night when I rang my call bell". This person told us they had not slept very well, felt unwell and were not feeling themselves. When we spoke to the day staff, they knew this person had been anxious and feeling unwell, as this important information about their well-being had been passed onto them by the night staff. A health care professional said that staff had a good knowledge of people's needs and any changes since their last review.

The service's 'statement of purpose' which set out the aims of the home, included meeting people's ", Intellectual, emotional and social capacity". However, visitors had mixed views about the activities on offer at the home. Some people told us there were always activities and others that there were few activities on offer in the lounge and none for people who remained in their own rooms. Staff said they rarely had time to sit and talk to people and activities were the responsibility of the activity coordinator was employed between 10am and 4pm each day. The activity coordinator was on leave on both days of our visit to the service. Each person had been asked about what they liked to do. However, the programme of planned activities and record of what activities people were offered did not always match. For example, one person's assessment stated they liked dressing up, but they had not been offered this activity. For another person it stated they enjoyed reminiscence, but they had not had access to their memory box. There were limited one to one activities available for people who did not enjoy group activities or who stayed in their rooms.

The lack of activities and stimulation to meet people's personalised needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the second day, the registered manager trained a member of staff to undertake activities for future occasions when the activity coordinator was absent from the home. People were asked if they wanted to join in art and craft, ball games and using musical instruments and streamers to beat in time with the music. This had a positive effect on people's well-being. They became engaged in the activities, smiled, exchanged conversations with staff and enjoyed themselves. In the afternoon the registered manager and a visitor danced together to the music and it turned out to be a lively and entertaining event. A music man and school choirs had been booked before Christmas and a party had been held.

Before people came to live at the service, the registered manager visited people and their relatives where possible to make a joint assessment as to whether the home could meet their needs. Assessments included aspects of people's health, social and personal care needs including their communication, mobility, nutrition, continence, skin care and breathing. A relative said, "When staff assessed my relative, they asked the right questions. They have settled in surprisingly well".

A plan of care was developed for each person, once they had moved to the home. This was done in a timely manner as a care plan was being developed for a person who had moved to the home the previous evening. This contained guidance for staff about the support people required in relation to their health, social and

personal care needs. Where a need had been identified a plan was in place for staff about how to support this person. For example, one person had been assessed as having poor eyesight. The person had been referred the optician. For another person there were detailed instructions in place which demonstrate that staff knew why the person became distressed at night time and the specific care and support staff should provide in this situation. People's care notes contained a 'This is me' plan with information about people's past occupation, family, likes and dislikes. Care plans were reviewed monthly to help make sure they were accurate.

People and their relatives said they knew how to raise a concern or complaint about the service and felt comfortable to do so. They said that the registered manager and staff were approachable. One relative said they had raised a concern to the registered manager. They said the registered manager listened to them, investigated their concerns and took the appropriate action to address them. The complaints procedure was available in the reception area and each person was given a copy when they moved to the home. This procedure told people how to make a complaint and the timescales in which they could expect a response. There was also information and contact details for other organisations that people could complain to if they are unhappy with the outcome. Complaints were recorded in a complaints log, investigated and complainants had received a response.

Requires Improvement

Is the service well-led?

Our findings

People and staff said the home was well-led. They said the registered and deputy manager were both approachable. Relatives said they were often asked about their views of the home, and that they were aware or attended relatives meetings. All relatives said they would recommend the service to others. One relative said they had been recommended the service and another relative told us they had recommended it to other people. Comments included, "It is the best place I have seen"; "My relative has lived her for a year and is over a 100 years so the home and staff must be looking after them well"; and, "We like the atmosphere here. Staff are really interested in people".

There were systems in place to review the quality of the service. Monthly audits were carried out, including infection control, health and safety, accidents incidents and falls, care plans, staff training and supervision. The provider checked these audits had been carried out on their monthly visits to the service. Their review form provided them with the ability to highlight any shortfalls and action that needed to be provided as a result, but no shortfalls had been identified by the provider. However, shortfalls were identified at this inspection in relation to medicines, staffing levels and activities. Relatives had voiced their concerns about the activity coordinator not being provided with enough hours to support people and as a result their hours had been increased by one hour a day. But the provider had not reviewed this increase in hours to ensure it was effective in providing people with the opportunity to take part in a range of stimulating and appropriate activities which met their individual needs and preferences.

This lack of a fully robust quality monitoring process was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's records were held securely, were clear, well organised and up to date. They were available to staff to access when they were required.

The aims, objectives and philosophy of the home were set out in the Statement of Purpose. Staff were clear about their responsibilities to people and to the management team. Staff said there was good communication amongst the whole staff team. The registered and deputy manager were both registered nurses and had clinical oversight of the service. The deputy manager worked full time as a nurse in charge of the care team and the registered manager was the full time manager. The registered manager led by example. She helped with the lunchtime meal, supported people to undertake activities, danced with a visitor and demonstrated that she knew relatives and people well. All relatives spoke highly of the registered manager and their skills in managing the home.

The registered manager had been proactive in developing good relationships with people's relatives and involving them in the care that was provided. Regular relatives meetings were held where their voice could be heard. She involved relatives in projects to improve the service, such as developing a tea room in the garden.

People and their relatives and staff were asked for their views about the service in a variety of ways. Relative

and service user meetings were held every few months where people were able to voice their views and information was given to people about up and coming events, new staff and future plans of the home. A staff survey in September highlighted that although most people felt supported, they would like praise for any work they had done well. As a result the registered manager introduced more in depth supervisions, staff events and was arranging champions in specialist areas.

Survey satisfaction questionnaires had been given to people in December 2015. People were asked whether they were treated with dignity, if the home was clean and if they were provided with activities. Most people had responded the service provided care to a good or excellent standard, and some people had rated the activities provided as satisfactory. Relatives were asked for their views about the level of care provided by the service in January and September 2015. The registered manager had reviewed the comments and an action plan was available to complete to address any shortfalls. It had not been necessary to complete this action plan as people were satisfied with the service and a large number of compliments had been received. Comments included, "I have never worried about the care my relative receives as it is 100 per cent. The food is excellent and the staff friendly and cheerful"; "I recommend the home because it's good all round"; "The staff are excellent a polite and willing to respond"; "As a visitor I have always been made very welcome and am happy "; and "All his medical needs are met and staff are well trained and they spend time ensuring he is happy.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and preferences in relation to stimulation and activities had been assessed, but were not being met. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were not clear protocols for staff to follow to ensure medicines prescribed as 'when required' where given appropriately. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system did not review the action taken to address shortfalls to ensure it was effective and resulted in the necessary improvements to the service. Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff on duty

Diagnostic and screening procedures

Treatment of disease, disorder or injury

to meet people's social and emotional needs.

Regulation 18 (1)