Thorncliffe Care Limited

Thorncliffe House

Inspection report

Thorncliffe
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Sunderland
Tyne and Wear
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Tel: 01915109736

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21 April 2017

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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

This inspection took place on 18 and 21 April 2017. The first day of the inspection was unannounced. This meant the provider and registered manager did not know we would be visiting.

Thorncliffe House provides personal care and accommodation for 24 older people. The service was supporting 16 people at the time of this inspection. Some people were living with dementia.

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

During this inspection we found the registered provider had breached two regulations of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

You can see what action we have asked the provider to take at the end of this report.

At the previous inspection we found care plans did not always contain up to date information. During this inspection we again found care plans were not always up to date. Where people were recorded as needing additional safety checks, no records were maintained to demonstrate checks were made. Risk assessments were in place for people; however some risk assessments were not recorded accurately.

The registered provider had a quality assurance matrix in place to ensure that audits were carried out on a regular basis. The quality assurance audits at this inspection had not identified the concerns we found in relation to record keeping.

The provider did not have evidence to demonstrate how the audit process was used to develop the service. No overall action plan was available to record managerial review and monitoring of the service to drive improvement.

Medicines were administered by trained staff who had their competencies to administer medicines checked regularly. Medicine administration records (MAR) were completed with no gaps and medicine audits were completed regularly. Policies and procedures were in place for safe handling of medicines for staff to refer to for information and guidance. The provider had not copied people's medicine care plans regarding 'as and when' medicines to sit alongside their MAR as per the provider's medicine policy.

The registered provider used a dependency tool to ascertain staffing levels. We found staffing levels to be appropriate to needs of the service, these were reviewed regularly to ensure safe levels. Staff were visible throughout the building during both inspection days.

There were robust recruitment processes in place with all necessary checks completed before staff commenced employment.

There were systems in place to keep people safe. We found staff were aware of safeguarding processes and how to raise concerns if they felt people were at risk of abuse or poor practice. Accidents and incidents were recorded and monitored as part of the registered manager's audit process.

Staff training was up to date. Staff received regular supervision and an annual appraisal. Opportunities were available for staff to discuss performance and development.

People were supported by kind and attentive staff who clearly knew people well. Staff discussed care interventions with people before providing support. Advocacy services were advertised in the foyer of the service and were accessible to people and visitors. Staff knew people's abilities and preferences, and were knowledgeable about how to communicate with people.

People's nutritional needs were assessed and we observed people enjoying a varied diet, with choices offered and alternatives available. Staff supported people with eating and drinking in a safe, dignified and respectful manner.

People were supported to maintain good health and had access to healthcare professionals when necessary and were supported with health and well-being appointments.

The registered provider had an activity planner which showed a range of different recreational and leisure opportunities available for people. We observed people joining in a range of activities during the inspection. People enjoyed listening to music and were seen in conversation with staff.

People and relatives views and opinions were sought and used in the monitoring of the service. Processes and systems were in place to manage complaints.

The registered provider ensured appropriate health and safety checks were completed. We found up to date certificates to reflect gas safety checks, and electrical wiring tests had been inspected and deemed as safe

A business continuity plan was in place to ensure staff had information and guidance in case of an emergency. People had personal emergency evacuation plans in place that were available to staff.

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met. The provider was working within the principles of the MCA.

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.

Risks associated to people's health were assessed. We found some people's risk assessments were not always completed accurately.

Recruitment processes were robust in ensuring checks were made to ensure prospective staff were suitable to work with vulnerable people.

Staff levels were appropriate to the needs of the service. The registered provider used a dependency tool to monitor staffing level.
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Is the service effective?

Good

The service was effective.

Staff received training to meet the need of the service and had regular supervision and appraisals to provide opportunities for learning and development.

Staff had an understanding of the Mental Capacity Act (2005) and Deprivation of Liberties Safeguards (DoLS). People's rights were upheld and protected by the service.

People had access to health care when required.

Is the service caring?

Good

The service was caring.

Staff knew people well and had caring relationships with them. People were treated with respect in a dignified way by staff that supported their independence.

The service had information regarding advocacy which was available to people, relatives and visitors.

People's rooms were personalised containing items that were

important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were personalised and contained people's likes and dislikes and preferences. We found some were not always up to date.

People, relatives and visitors had opportunities to complain, give comments or raise issues.

The service had received several positive compliments about the care they provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's quality assurance process had not identified concerns with risk assessments and care plans.

The registered manager did not have any action plan to record managerial review to drive improvements.

People and relatives felt the service was well managed with a supportive manager and team in place. The registered manager was described as open and approachable.

Opportunities were available for people, relatives and staff to meet on a regular basis.

Thorncliffe 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 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 18 and 21 April 2017 and the first day was unannounced. This meant the registered provider did not know we were coming.

The inspection was carried out by one inspector.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to the Care Quality Commission (CQC) within required timescales. We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with five people who lived at Thorncliffe House. We spoke with the registered manager, the deputy manager, four care workers, the activities coordinator, one ancillary staff member and the cook who were all on duty during the inspection. We spoke with one health care professional who was visiting the home. We also spoke with three relatives of people who used the service.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of three people, the recruitment records of two staff, training records, and records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Thorncliffe House. One person told us, "Oh yes, safe as houses. The girls are very nice." Another said, "I am definitely looked after here, no complaints here." Relatives felt their family member was safe in the home. One told us, "I have not got one concern, she [person] is safe, the lasses are really good." A second relative said, "They [staff] look after [person] extremely well, they are so gentle, I pop in so I see everything." One visiting health care professional told us, "The service manage [person] really well, they are consistent with them."

We found people had risk assessments within their care files. However we found some risk assessments were not completed accurately. One person's pressure area risk assessment had not been completed accurately. The score used for the person's body mass index (BMI) which formed part of the overall assessment was not correct. The actual score for the pressure area risk should have read 19 not 16 as previously recorded. Which meant the person was at greater risk of pressure damage. We discussed this with the deputy manager who reviewed the record and made the necessary amendment. This meant that we could not be sure risk assessments were completed accurately.

For example, one person's risk assessment for pressure area care was scored but not totalled. We totalled the risk assessment and found the person was at very high risk of pressure areas with a score of 28. The person's SSKIN bundle (a type of record used for people at risk of pressure damage) stated they should have two hourly care but the SSKIN bundle daily records were completed four hourly. We discussed this with the deputy manager who advised us the person did receive two hourly support.

Another person's pressure area risk assessment had not been completed accurately. The score used for the person's body mass index (BMI) which formed part of the overall assessment was not correct. The actual score for the pressure area risk should have read 19 not 16 as previously recorded. Which meant the person was at greater risk of pressure damage. We discussed this with the deputy manager who reviewed the record and made the necessary amendment. This meant that we could not be sure risk assessments were completed accurately.

The provider had recently introduced a new medicine management policy and procedure. The policy stated where people were prescribed 'as required' medicines a copy of the medicines care plan should be aligned with the MAR so staff had guidance as to when to administer the medicines. As required medicines are medicines used by people when the need arises, for example medicine for pain relief used for headaches. No medicine care plans were found in the MAR file. We discussed this with the registered manager who advised this would be addressed.

A fridge was available to store medicines that required cool storage. Records confirmed that temperatures were checked and recorded daily. Each person had a medicine file which contained the most current Medicine Administration Record (MAR). Records gave clear instructions on what medicine people were prescribed, the dosage and timings. The MARs were completed correctly with no gaps or inaccuracies. Staff were trained and had their competency to administer medicines checked annually. We reviewed seven

people's medicine administration records. These were completed correctly with no gaps. Topical MAR's were in place. (Topical MAR's are used to record the application of prescribed creams and ointments.)

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. For example, two references and Disclosure and Barring Service checks (DBS) were completed. These were carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

Environmental risks were assessed and reviewed to ensure safe working practices for staff were in place, for example, to prevent slips, trips and falls.

People and relatives felt there were plenty of staff on duty. Staffing levels were monitored by using a dependency tool. The deputy manager told us, "This is reviewed on a weekly basis, when the rota is done." During the inspection staff were visible and call bells were answered in a timely manner.

The service had a range of policies and procedures to keep people safe, such as accident, incident, safeguarding and whistleblowing procedures. These were accessible to staff for information and guidance.

Staff we spoke with had a clear understanding of safeguarding and were able to give examples of how people may present if they were being abused. One care worker told us, "We could find unexplained bruising, or they might become upset. I'd notice that, if they were not usually emotional." Another said, "I would report anything to the manager. Someone could be confused or scared." A third care worker told us, "You could notice a change in body language, I would whistle blow straightaway, no problem." All the staff we spoke with felt the registered manager would act if they reported an allegation of abuse.

The registered manager kept a safeguarding referral log containing notifications sent to the Commission along with the local authority consideration logs. Consideration logs are documents submitted to the local safeguarding team to assess the incident. Documents contained details of action taken and outcomes along with the lessons learnt. Staff were made aware of lessons learnt through staff meetings or supervisions.

We found staff had received training in safeguarding during induction and training was refreshed on a regular basis.

The registered provider ensured the maintenance of equipment used in the service and health and safety checks were in place. We found up to date certificates for gas safety checks and electrical wiring tests.

The service followed infection control procedures and provided personal protective equipment (PPE) for staff. Plastic aprons and gloves were kept in people's bedrooms for staff to use.

The registered manager had updated people's personal emergency evacuation plans (PEEPs) to show which people had a key to their own rooms and those who would need additional assistance in the event of an evacuation. These were held in a metal cabinet in the foyer for easy access. The provider had a business continuity plan in place. This meant staff had access to information and guidance in case of emergency.

Good

Is the service effective?

Our findings

People and relatives felt staff were well trained and had the skills and knowledge to support them or their loved ones. One person told us, "They know what they are doing." Another said, "Whatever I need doing they are there, they know how to look after me." A third person commented, "I would say so" (to staff being appropriately trained). One relative we spoke with told us, "They look after [person] well, they are trained, there is no problem there." A second relative said, "They are brilliant, really on the spot. They know when [person] may have a water infection so know when medication is needed."

The provider had an induction process in place. We found staff completed essential training as well as shadowing experienced staff as part of their induction in to the service. Staff we spoke with felt confident and suitably trained to support people effectively, training was refreshed on an annual basis. One care worker said, "Training is really good, we do lots of training, there is a yearly programme." Another care worker told us, "My training is up to date, we do it all the time. I like to do the training it refreshes your memory."

The registered manager had an annual planner in place for staff supervision and appraisal. We found records to demonstrate staff received their appraisal and had supervision on a regular basis. Records demonstrated staff discussed on-going development to support their learning. We found one care worker had requested more training, and this had been arranged. Another staff member had been nominated to completed extensive falls training to develop their knowledge.

One staff member told us, "I have mine with [deputy manager], we talk about what I want to improve on, or any concerns or issues." Another care worker commented, "[registered manager] does my supervision. My appraisal is more in-depth we talk about how I was getting on, and how I felt about allocating jobs to the girls."

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and found any conditions on authorisations to deprive a person of their liberty were being met.

Where people lacked capacity to make decisions, MCA assessments and best interest decision meeting records were available. The registered manager kept a record of all DoLS applications made along with copies of authorisations. Care workers clearly understood the importance of empowering people to make as

many of their own decisions and choices as possible. These included explaining options to people and anticipating needs for some people by observing facial expressions and body language. We observed staff supporting people to make decisions regarding meal choices and attending activities.

People were offered a healthy varied diet, with food and fluid charts completed where required. We observed the lunch time meal and noted this was a pleasant dining experience for people. Tables were set with flowers, napkins, cutlery and condiments. Where necessary people were provided with aids to support them eating and drinking. For example, plate guards. Plate guards assist people to eat with one hand to prevent spills. One person chose to wear protection for their clothes when eating. One staff member told us, " [Person] likes to wear one [clothes protector] rather than use the napkins." Staff addressed people in a friendly manner. We observed one staff member repeatedly reassuring a person who was becoming distressed. The staff member comforted the person, gently crouching down next to them and remaining with them until they started to eat their meal again. We saw one person was offered a drink of two different flavours of juice, when they could not decide. The staff member showed them the jugs of juice so they could see the colours and make a choice. During the inspection we saw people being offered cups of tea, coffee, biscuits and snacks. One person told us, "One thing I can say is the food is good." Another told us, "The food is nice, I really enjoy my porridge and toast, and sometimes there are things I don't like so they offer me something else." A third told us, "I sometimes have soup rather than the meal, they are happy to do that for me." The cook had information about specialist diets. They told us, "I have a list of who has what, the girls keep me up to date."

Care records confirmed people had access to external healthcare professionals when required. We found people attended health care appointments and were visited by the dietician and podiatrist on a regular basis. We spoke with one visiting healthcare professional during our visit. They told us, "Staff recognised changes in [persons] behaviour and got the GP in, they manage [person] needs well." Community nurses visited the service on a daily basis. The deputy manager told us, "We can always speak with them if we have any concerns." By having such a close working relationship with community nurses people's health care needs were addressed in a timely manner.

Communal areas were set out with easy chairs, televisions and, or radios were available for people to watch/listen to. Signage was in place for people to orientate their way around the home, such as toilet signage and exits.

Good

Is the service caring?

Our findings

People and their relatives gave us positive views when we asked them about the care provided at the service. One person told us, "They are as good as gold here, I cannot grumble." Another said, "I get up whenever I want, sometimes early sometimes late, they make me a good cup of tea." One relative told us, "They call the doctor, nothing is too much trouble; they always pop in [to person's room]." Another said, "The staff here are so friendly, they look after [person] well." One healthcare professional told us, "They are warm and welcoming, I have no issues with the care here."

We observed care workers showed genuine affection during their interactions with people. When communicating with people we saw staff waited for people to respond. Staff clearly explained options which were available to the person and encouraged them to make their own decisions. For example, what they preferred for lunch or whether they wished to join in the activities. Staff were friendly, caring and showed warmth in their conversations with people, crouching down to maintain eye contact, using facial expressions, gestures and touch to communicate. Staff spent time with people in the communal areas, engaging in conversations and having a laugh and a joke.

People were cared for by care workers who knew their needs well. People were treated with dignity and respect. Care workers told us they ensured people had privacy when receiving care. For example, knocking on people's doors before entering, keeping doors and curtains closed when providing personal care and supporting people to go to their rooms.

When people were supported with eating and drinking staff used prompts at a pace appropriate to them. We observed one member of staff prompting a person with their lunch, taking time to make sure they were eating, and then returning to check they were still eating.

We found personal care was attended to discreetly and clothing changed to maintain dignity. Staff clearly understood peoples preferences and were knowledgeable about the care they required. Staff explained to people what they were going to do before they acted and gained consent either verbally or by gestures.

Staff used people's preferred names and actively encouraged decision making. A care worker stopped and asked, "Do you want a top up of tea that one must be cold now." The activity coordinator was seen asking people if they wished to attend the planned activities. People were supported to be as independent as possible. Care workers said they encouraged people to do as much for themselves as possible. One care worker told us, "I always promote their independence as much as possible; [person] has a walking frame so I always encourage them to use it." Another said, "It is better to support them to do something rather than to take it away and do it for them."

Information was readily available to people, relatives and visitors about independent advocacy. The registered manager advised us that two people had involvement from an Independent Mental Capacity Advocate (IMCA) who was supporting them. The role of the IMCA is to support and represent people at times when critical decisions are being made about their health or social care. They are involved when the person

lacks capacity to make these decisions themselves and mainly when they do not have family or friends who can represent them.

People's rooms were comfortable, some with pieces of their own furniture and items which were personal to them and each room reflected the person's interests and character.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained personalised information that included details on maintaining people's health, likes, dislikes and their daily routines. We found not all of the plans set out what people's needs were and how they should be met.

At the previous inspection we noted one person had bed rails in place to prevent falls. The information regarding the use of bed rails was not within the person's care plan. During this inspection we found a risk assessment was in place for the use of bed rails but there was no detail within the person's care plans. We discussed this with the deputy manager who reviewed and amended the care plan immediately.

Another person's care plans stated they required their food cut up in to very small pieces. We found other records relating to the person indicated some meals were blended. We reviewed their eating and drinking care plan and found no records pertaining to blended food. We discussed this with the deputy manager who advised the person preferred some meals blended and added details to the care plan.

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

Some care plans were extremely personalised. One person's communication care plan stated, 'Staff to use my facial expressions and body language as I often express my likes and dislikes this way, I will smile and appear relaxed when I am content, if I am not feeling cooperative I will frown, grit my teeth and at times can lash out.' Another person's care plan for medicines stated, 'I am on anticoagulants and need regular blood tests, I would like my tablets placed in my hand followed by a drink.'

Staff told us they felt there was sufficient information and guidance to be able to support people safely and in the way they wished. Examples included, '[person] prefers a female carer', '[Person] likes to wear blue.' Another care plan stated, 'I am most content when I am busy, I enjoy dusting with the staff.' This meant people were being supported and cared for in an individualised way with their preferences being acknowledged. Staff commented that relatives were involved in writing people's care plans. One care worker told us, "We are working on care plans. It's important to get as much information about the resident as possible." Another care worker said, "I am key worker for [person] so I know all about her, how she needs a hand with things; she loves having her hair dried and set, loves to go out, and enjoys bingo and dominos."

People and relatives told us they felt the service provided personalised care and that the staff were skilled. Relatives told us they were involved in people's care planning and that staff were responsive to their family member's needs. One person told us, "They [staff] talk to me about how I get looked after." One relative told us, "I am always involved in what is going on with [person]; they let us know if they've had a bad turn." Another said, "Oh they are good, they keep an eye on [persons] weight, we often speak with [registered manager] about how they are getting on." A third told us, "They call the doctor out, and then let us know. I am in three to four times a week, nothing fazes them here, the girls are fantastic."

We spoke with a visiting healthcare professional who felt the service was responsive to people's needs. They told us, "I have no issues at all. I always get a good update from staff, they are consistent, [person] is happy here."

People were supported to maintain hobbies and interests. Activities were on a four weekly planner, we found a different activity was recorded each morning and afternoon. People could join in arts and crafts, sing-a-longs, and the movie morning or evening with popcorn. One person told us, "I like to read the paper, then I'll join in the quiz. I have people from the church come in and I enjoy the dominos." Another told us, "I like it when the singers come in." A third said they enjoyed the odd game of bingo and to sit in the garden.

We spoke with the activity coordinator who told us, "We can change things around if need be, I speak with people to see what they like to do. If they don't want to join in what's planned there is always something else to offer." The registered manager told us, "We also have people baking; I am always surprised how many of the men like to join in."

The registered manager told us about a new initiative the home was involved in. The provider had started work with Age UK joining their Friends and Neighbours of Sunderland project (FANS). The Friends & Neighbours Sunderland project aims to work with care homes in Sunderland to promote, encourage and support the development of networks of people, members of groups and organisations to take an interest in the well-being of people who live in local care settings. One meeting had already been held to set out how homes were going to be involved. The registered manager told us, "We are excited to be part of this; I think it will be really good for the home."

We found the provider had a process in place for people, relatives and visitors to complain and give comments or raise issues. The policy and procedure was kept in the reception for easy access. Everyone we spoke with said they felt they would be able to complain to care workers or managers if necessary. All complaints were logged, investigated and where necessary, discussed with staff as lessons learnt during supervision or team meetings. Two of the complaints registered were seen with satisfactory results. One was not yet concluded.

Requires Improvement

Is the service well-led?

Our findings

The provider had a quality assurance system in place to cover areas such as care plans, medicines, accidents and incidents. During the inspection we found issues with recording in people's risk assessments and lack of detail in nutritional care plans which had not been highlighted by the providers' care plan and risk assessment audits. One person's care plan had not been updated following the previous inspection. Despite this being recorded in the previous inspection report.

We found the registered manager did not have a system to demonstrate how the audit process was used to develop the service. No overall action plan was available to record managerial review and monitoring of the service in driving improvements. This meant we could not see how the service planned to improve and develop.

The provider had recently introduced a new medicine management policy and procedure. The policy stated where people were prescribed 'as required medicines a copy of the medicine care plan should be aligned with the MAR so staff had guidance as to when to administer the medicine. No medicine care plans were found in the MAR file. This meant the registered manager had not reviewed the policy to ensure staff had the appropriate guidance as part of the service's governance systems to provide the guidance necessary when administering as required medicines.

Although these issues were either rectified at the inspection or agreed with the registered manager that action would be taken, this demonstrated a reactive approach. This meant we could not be sure the quality assurance process was effective in monitoring the service.

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

The provider visited the home regularly to meet with the registered manager to discuss the service and how to drive improvements. We asked the registered manager if they had an action plan or development plan in place using the results from quality audits in order to drive improvements. The registered manger told us, "We do not have an action plan or a development plan if anything is needed we just do it there and then. [Provider] comes down regularly and I just tell him what we need to do." We asked if there were any recordings of the discussions held with the provider. The registered manager said, "No, we just talk about things, after every inspection we always say we need to have something in place."

The registered manager had developed an audit matrix. Setting out when audits were due to be completed. We found records to demonstrate medicine audits had been completed with actions signed off by the deputy manager. Care plan audits were completed by the deputy manager with a random percentage reviewed by the registered manager. We found people were asked for their comments following the dining experience audit. All the responses were positive, people enjoyed their meals.

People and relatives we spoke with told us the service was well led. Everyone we spoke with knew who the

registered manager was and felt they could approach them or the deputy manager with any concerns they had. One person told us, "They [registered manager] come around the home every day." Another said, "I have no complaints, [registered manager] pops in, I also know [the provider]." One relative told us, "I get on well with [registered manager]." Another told us, "[registered manager] is more than approachable."

Staff told us they felt the service was well managed and the registered manager was very open and supportive. One staff member told us, "They [registered manager] are fine, I can go to them with anything, she does a walk around to check on everyone." Another said, "I could go to either [registered manger] or [deputy manager] they would both listen if you had a problem."

Staff meetings were held regularly and minutes were made available for anyone who could not attend. The registered manager told us, "I have regular meetings with relatives and residents but anyone can pop in at any time." We found records to show meetings were held on a regular basis.

The service had a registered manager in place. The CQC registration was on display along with a copy of the most recent inspection report. We saw that the registered provider ensured statutory notifications had been completed and sent to the CQC in accordance with legal requirements. The home kept all personal records secure and in accordance with the Data Protection Act.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care plans contained accurate information to meet the needs of the service user. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance processes did not identify where people's risk assessments and care plans were not accurate or up to date. The provider did not have any system to demonstrate how improvements were reviewed and signed off. Regulation 17 (2) (a)(b)(c)