Quantum Care Limited

Belmont View

Inspection report

Hailey Lane
Hailey
Hoddesdon
Hertfordshire
SG13 7PB
Tel: 01992 450304
Website: www.quantumcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Belmont View provides accommodation and personal care for up to 85 older people. The service is not registered to provide nursing care. There were 83 people accommodated at the home at the time of this inspection.

The inspection took place on 04 August 2015 and was unannounced. We last inspected the service on 27 June 2014 and found the service was meeting the required standards at that time.

The home had a registered manager in post who had been registered since October 2010. 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.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty

Summary of findings

Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Belmont View and a number of these were pending an outcome.

People told us they felt safe living at Belmont View. Staff were aware of how to keep people safe and risks to people's safety and well-being were identified.

We found that the home was staffed sufficiently and was calm throughout our inspection.

There were suitable arrangements for the safe storage, management and disposal of people's medicines, including controlled drugs.

Staff had the skills and knowledge skills necessary to provide people with safe and effective care and support. Staff received regular support from management which made them feel supported and valued.

People were supported to make their own decisions as much as possible.

People did not always receive appropriate support or encouragement to eat and drink sufficient quantities.

People had access to a range of healthcare professionals when they needed them.

The views from people about receiving the right care and support and being involved in developing their care plans was mixed.

There were activities in place and visitors were encouraged to visit at any time of the day. We observed throughout that people's privacy was promoted.

There were arrangements in place to obtain feedback from people who used the service, their relatives, and staff members about the services provided. People told us they felt confident to raise anything that concerned them with staff or management.

People's care records did not always contain sufficient detail to provide a comprehensive account of a person's needs and care.

There was an open culture in the home and relatives and staff were comfortable to speak with the manager if they had a concern.

The provider had arrangements in place to regularly monitor health and safety and the quality of the care and support provided for people who used the service.

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?
The service was not always safe.

Staff were aware of how to identify and report abuse, however were not aware of organisations outside of the provider to report this to.

Incidents and accidents in the home had been recorded and investigated.

Risk assessments had been completed where required.

People's medicines were stored and administered safely, however guidance for medicines when needed was not available to staff.

The majority of the home was clean, however one unit was poorly maintained, dirty and in one area had a strong malodour.

Requires Improvement

Is the service effective?
The service was not always effective.

People received support from staff who were appropriately trained and supported to perform their roles.

Staff sought people's consent before providing all aspects of care and support.

People were not always appropriately supported to eat and drink.

People were supported to access a range of health care professionals ensure that their general health was being maintained.

Requires Improvement

Is the service caring?
The service was caring.

People were treated with warmth, kindness and respect.

Staff had a good understanding of people's needs and wishes.

People's dignity and privacy was promoted.

Good

Is the service responsive?
The service was not always responsive.

People were supported to engage in a range of activities.

People's care records did not always contain sufficient detail to provide a comprehensive account of a person's needs and care.

People's concerns were taken seriously.

Requires Improvement

Is the service well-led?
The service was not always well led.

Requires Improvement

Summary of findings

People had confidence in staff and the management team.

The provider had arrangements in place to monitor, identify and manage the quality of the service.

Audits had not identified that people's care records were not up to date to ensure they were accurate and comprehensive.

The atmosphere in the home was open and inclusive.

Belmont View

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 met 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 under the Care Act 2014.

This inspection took place on 04 August 2015 and was unannounced. The inspection team was formed of two inspectors and a specialist nursing advisor who had experience of dementia care for elderly people.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, we spoke with nine people who used the service, nine members of staff, the registered manager and two members of the provider's senior management team. We spoke with six relatives to obtain their feedback on how people were supported to live their lives. We received feedback from representatives of the local authority health and community services. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to nine people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Belmont View. One person said, "It's like a home from home." Another person told us, "The staff are all so very kind and look after us very well, I am not concerned by anything here, and quite happily sleep with my door open." One person's relative told us, "When I leave and go home in a while I will know [relative] is safe and content, which then helps me get on with my life."

On arrival we toured the home and found the vast majority of the areas was clean bright and welcoming. We observed cleaning staff throughout the day carrying out their duties both in communal areas and in peoples rooms. Staff were observed throughout the day wearing the appropriate protective equipment such as aprons and gloves when assisting with personal care or when handling people's meals. However, one unit we went into was not maintained to the same standard of cleanliness. Shortly after breakfast we went into the kitchen of Rowan. Residents and staff were not present; however we saw a packet of butter left open on the work surface, ham sitting in silver foil was also left uncovered and the top was off a milk carton all left in direct sun light. The kitchen was in a general state of untidiness and was unclean. The kitchen units were chipped, the bin lid was open with rubbish overflowing. The work surface was not clean and had a dirty cloth and two used blue towels strewn across it. The floor was dirty and sticky. We showed this to the deputy manager who then instructed staff to clean the area.

On the same unit, whilst walking with the manager we noted a used continence pad left on the floor in the toilet, and a strong smell of urine emanating from the carpet in Rowan unit. The manager told us that they had identified the carpet as needing replacing as well as the kitchen and had requested the works to be done. One person's relative told us, "I have an issue with sticky floors, but their room is clean." We saw from audits that had been carried out that each area we identified had been reported to the providers facilities team a number of months previously. However, no action had been taken to remedy the works. The regional manager contacted the provider whilst we carried out our inspection and once again highlighted the repairs that were required. We were told that authorisation for the works had been made, and subsequent to the inspection we were informed by the manager that work to replace the kitchen, carpets and units was due to begin shortly.

Upon arrival at Belmont View we quickly ascertained that there was no hot water available in people's rooms in two of the units. People who wished to wash in their rooms in the morning were unable to do so. One person told us, "I went to have a shave and again there was no hot water in my room, so I didn't bother with it." Staff and people told us the water had been off since the previous Saturday evening. People were able to bathe and shower on other units, but did not have hot water in their rooms to wash themselves should they choose to. The management team had reported this to the provider's maintenance team, who had arranged for an engineer to visit. However the works were not completed on the morning of our inspection. We spoke with the manager about this, who once again contacted the maintenance team, who then ensured the water was repaired by the time our inspection was completed.

The provider had not ensured that people lived in a hygienic, clean environment, and had not made arrangements for repairs and replacements to be made once identified in a timely manner.

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

Staff spoken with about protecting people from abuse were able to describe to us what constituted abuse and what signs they looked for when supporting people. One staff member told us, "Our job is not to look just for abuse, but also any signs of abuse and when we suspect something is not right to let the manager know." We asked staff about reporting procedures, who all told us they would complete the relevant paperwork, and also inform the management. However, when we spoke with staff about whistleblowing procedures, they all told us they would report concerns about staff practice to either the manager or their head office. When asked about other organisations they may be able to report concerns to, such as the Local Authority or the Care Quality Commission, only two were aware of this. This demonstrated to us that although the provider had taken reasonable steps to ensure staff knew how to identify aspects of abuse, not all staff were aware of how to report concerns outside of the organisation.

Requires Improvement

Is the service safe?

We looked at how incidents and accidents were managed in the home. We saw that where an incident had occurred, staff had completed the appropriate form which had then been reviewed by a member of the management team. Management then reviewed the incident and took appropriate actions, and if required referred the matter to the local authority. One staff member told us that the managers actively encouraged them to report any incidents or accidents. However, care plans had not always been robustly reviewed in response to incidents.

People, relatives and staff spoken with told us they thought there was always enough staff on duty. People told us that staff responded quickly when they used their call bell to request assistance. The manager regularly used a dependency assessment tool to review the needs of people. This tool considered the health and support needs of people, and how long it took to assist each person during the day. We saw that this tool helped ensure that the correct staffing levels were provided.

We reviewed recruitment records for four staff members and found that safe and effective recruitment practices were followed which ensured that staff did not start work until satisfactory employment checks had been completed. Staff we spoke with confirmed that they had to wait until the manager had received a copy of their criminal record check before they were able to start work at the home. This ensured that staff members employed to support people were fit to do so.

The management team and provider operated an on call system for staff to receive managerial support and out of hours support in the event of an emergency. People had individualised emergency evacuation plans which were clearly identified in the care records. Staff spoken with were able to describe procedures to be followed in the event of an emergency, for example if there was a fire.

There were suitable arrangements for the safe storage, management and disposal of people's medicines. Each person had a completed medicine administration record (MAR) which recorded the medicines that people were prescribed and when to administer. There were no gaps or omissions in the MAR, and staff maintained an accurate stock count of medicines with frequent stock counts. The temperature of both the medicines room and fridges was monitored which ensured that people's medicine were stored within safe temperature limits. Where stocks were received and disposed of, accurate records were maintained and checked by two staff members for accuracy. People's MAR's were complete with an up to date photograph which ensured staff could identify the person correctly prior to administering their medicine. This sheet also contained details about people's allergies such as penicillin or food allergies.

Where people were prescribed medicines that had side effects such as drowsiness, staff monitored people and referred to the GP if there were any concerns. For example, one person's medicines had caused them to be very sleepy , we saw that this had been monitored by staff and reviewed by the GP in order to adjust the medicine to a more appropriate level and to reduce the side effects this medicine had caused

However, where people had been prescribed 'as needed' medication (PRN) such as pain relief or medicines to aid their sleep, guidance was not available to staff to determine when to use these medicines. For example, where people were unable to communicate verbally that they were in pain, or anxious, there was not a personalised guidance document contained in the medicine record that instructed staff when to use these medications. We saw that where staff had noted people's individual signs that they required PRN medicines, they were generic. One record noted, "Use facial expression that might indicate pain such as grimacing, wincing, crying or pain on movement." There was nothing recorded to specifically identify how this person would communicate to staff they were in pain. This did not give consideration to people's individual ways of communicating, which meant people may not receive their PRN medicines when required. However, subsequent to our inspection the manager told us they have implemented this system.

Requires Improvement

Is the service effective?

Our findings

People told us they thought the staff were well trained and supported to care for them. One person told us, “They are the cream of the crop, and [Staff member] is the cream who floats to the top of the pile.” Another person told us, “I don’t have any complaints really, the new staff need a bit of guidance but they get that from the experienced ones.”

Staff told us that they received effective training which ensured they were able to provide the appropriate support and care to people. Newly recruited staff members completed an induction programme and shadowed an experienced staff member until they had been assessed as competent to lone work. Staff we spoke with told us they felt supported by the management team, including senior management and received regular supervision from a line manager. Staff said they felt able to discuss their role and any difficulties which their line manager or colleagues which they said helped them to feel supported and able to develop their skills and competencies. One staff member told us, "I think we have a great support network here, I can ask advice about anything I need and they listen and help me to develop.” This demonstrated to us that people were looked after by staff that had the knowledge and skills necessary to provide safe, effective care and support.

Staff we spoke with told us they received training in caring for people with dementia. Initial training was part of their induction and once they had passed their six month probationary period they completed a further three day course in dementia care. All staff said training was good and they had regular updates. One staff member said that apart from the required training for example in moving and handling people, health and safety, safeguarding and medication they received considerable informal training from more experienced carers who were happy to share their skills.

Staff were observed to gain peoples consent prior to assisting them with tasks such as eating, personal care or continence needs. Staff ensured they clearly explained to people what they needed to do, and waited for the person to respond. If the person was unsure then staff explained once again and waited for the person to agree.

Staff told us they had received training about the MCA 2005 and DoL’s and that they understood what it meant. The manager told us that this training was now included in the Quantum Care staff induction package. Staff were able to describe how they supported people to make their own decisions as much as possible such as with their personal care and daily choices. We saw that records of assessments of mental capacity and ‘best interests’ documentation were in place for people who lacked capacity to make their own decisions. The management team demonstrated a good understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Belmont View and were awaiting an outcome.

People told us they enjoyed the food provided at Belmont View. One person said, “It’s not home cooking, but the food is very good, there is a range of different things and if I let the staff know in time then they’ll find me something else.” Another person told us, “The food is good and you get enough too”. We observed people having their breakfast and lunch. People’s breakfast was served according to people’s own preference for example if people ate in their room or dining area, the time and choice of breakfast, we observed numerous people having a variety of cooked breakfast, which had been individually and freshly prepared by staff. The tables were laid attractively to encourage people to eat and a range of fresh fruit was available. People who required soft or pureed foods were provided with this, and staff were aware of people’s individual needs.

However we also observed in some people’s rooms food and drinks had been left uneaten. We observed at breakfast a number of people in their rooms with cold tea and toast left uneaten. One person’s relative commented they had seen people’s almost untouched food being taken away by staff. When staff did take people’s meals away we noted they did so with comments such as, “Didn’t you want your meal today,” and then later offering a pudding but not an alternative main meal. Where people required assistance with their meal, this was not always provided in a timely manner. We observed at lunchtime that some people had difficulty in using their cutlery. Staff did not intervene on one unit to support people, which meant they did not eat as much as they may have done had they been supported. One person’s relative told us that staff had left their relative with a meal in their room with a knife and fork that they were unable to use independently the previous

Requires Improvement

Is the service effective?

day to our inspection. They visited them later that evening and saw the meal had been left. They told us that they then felt they needed to request an alternative meal so that their relative had sufficient to eat that day.

Where people lost weight or were at risk of losing weight we saw that dieticians and speech and language therapists (SALT) had been consulted. People were weighed regularly and had a food and fluid chart in place which was monitored by a manager daily. However charts we looked at were not all completed in a consistent way so it was difficult to gauge how much someone had actually eaten. This would make it more difficult to assess people's dietary intake if they were at risk of weight loss. However, not all the people who had their meals and fluids recorded had been assessed to require this. We spoke with the manager about this who said they would review this following our inspection to ensure the records were both fully accurate and for people who required them.

People said they could always see a doctor and they had a visiting dentist in addition to chiropodists, district nursing teams, opticians and being supported to attend hospital appointments. We spoke to staff about one person who could not access the bath safely because of their condition. Staff said they were in the process of referring the person an occupational therapist for an assessment.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the care they received from staff at Belmont View. One person told us, “They are a very warm and tender group of people.” A second person told us, “Naturally I prefer my own family, but this lot are a good second option when I can’t see my own.” One person’s relative told us, “The real positives are the carers, they are really involved, they really know [person] and keep them involved.”

We observed constantly throughout the inspection warm and kind interactions between staff and people. For example we observed one staff cooking breakfast on one unit for people. There was an altercation between two people behind the staff member and they swiftly turned round and diffused the situation by finding suitable distractions for each person. One person clearly wanted to assist the staff member with cooking, and was then asked to help with buttering bread and laying the tables in the dining room. Staff wore their own clothes which helped to create less of an institutional environment and people were free to walk around the entire home, which gave a community feel. Numerous people from various units were seen sitting in the communal gardens enjoying a warm and sunny day.

Staff were knowledgeable about people’s individual needs and preferences in relation to their care and we found that people were also involved in discussions about their care. Relatives we spoke with told us that staff kept them well informed about the persons care, and felt that staff gave people a wide range of choice about how they received their care. We observed throughout our inspection that staff gave people as much time as they needed to consider their options, and patiently explained these choices to them. These ranged from simple decisions such as whether someone wanted breakfast in bed, or what time they wanted to get up to how they wished to spend their day, and with whom. One person’s relatives we spoke with were not happy with the care their relative had received from staff. They told us they felt the attitude of staff did not support the person’s needs well, and when they requested additional support this was not given. However, the manager was aware of this, and told us on the day of the inspection they were looking at moving the person to a different unit that may be able to support the person’s more complex needs.

One person’s relative told us, “I live a long way away so my [relative] has more day to day involvement, but anytime I need to know anything or speak to the home they keep me well informed about [person].” A second relative told us, “When I phone or come in, there is always someone who knows [person] that I can speak to.”

We saw that people were free to have their bedroom doors open or closed, and in one example we saw that the person chose to lock their bedroom door for privacy. When staff entered people’s rooms, they knocked and waited for a response before proceeding into the bedroom. When staff walked in to the bedroom we heard them introduce themselves in a friendly manner, and then close the door to protect the person’s dignity prior to assisting them. When people in communal areas required support with going to the bathroom, staff spoke softly to the person and discreetly took them with minimal fuss.

Requires Improvement

Is the service responsive?

Our findings

The views of people about receiving the right care and support and being involved in developing their care plans was mixed. One person told us, "I like to get up early and go to bed early, I can here." A second person told us, "It is hit and miss depending who is working, sometimes it's fine and they get on with it as I like, sometimes I have to tell them again and again how I want things done." One person's relative told us, "Sometimes the staff just need to listen to us, we know [person] so much better than them and it helps to know those little things."

Overall care was centred on people's needs and people's families had been involved in informing staff of the person's life history, interests and preferences. Staff were generally committed to ensuring people received care that was personalised and tailored to the individual's needs. For example on one unit, a staff member told us how they had patiently worked to understand one person to better support them. This person became agitated and displayed behaviours that challenged to both staff and other residents. The staff member told us they had spent time researching dementia, speaking with family and seeking advice from management in order to develop the care plan. They told us they had listened to these views and developed a plan that minimised the person's behaviours. They said, "I tried to understand why, and quickly realised part of the issues were [person] became agitated in a female dominated environment where it was noisy and full of distractions. We quickly understood [persons] family background which helped us to find appropriate solutions that have worked positively. For me the two most important documents are the one page profile and definitely the family history as that gives us a link to the person."

People's relatives told us that generally they felt involved in reviewing their relatives care. They told us they were able to freely comment and contribute to the review and development of the care plan. One person's relative told us, "We have an annual review of [person] care on Thursday; there is a constant information exchange backwards and forwards."

However, on one unit, we found that one person was very private and sensitive about receiving support for personal care did not have this information within their care plan, describing how they like to be supported. This person became resistant to bathing and washing and staff at times found it difficult to carry out the personal care as they lashed out at the staff member. When we looked at the respective care plan it stated, "Prompt and encourage participation," but with no consideration given of why the person was resistant or how to positively encourage. We spoke with the manager and showed them the care plans that lacked personalised instruction or direction for staff. They told us they had a meeting arranged with the family, and would ensure the care plan reflected the person's needs and how to support them. They also told us they would review the one page profile sheets to ensure they robustly described people's needs and how to meet these in a personalised manner.

People and relatives told us they felt welcome to visit anytime and were actively encouraged to be involved. We observed one person's family had brought a picnic in and sat by the lake with no pressure from staff to return to the unit. People who were able to, told us they were free to come and go as they pleased and frequently went to either visit family or go out for short day trips or meals. There were a range of activities provided to people, both based in the community and also within the home. We saw that for those people who were able to go out, events that had been held included church services, trips to garden centres, zoo's, local pubs and shopping. For those people who were unable to go out unaccompanied, such as those who were subject to a DoLS or bed bound, staff provided appropriate activities. These included entertainers, music, films, and impromptu interactions with staff such as having a walk in the grounds or having a cup of tea. One staff member was heard to say to a person who appeared unsettled, "Do you want to sit with me and have a cup of tea or can I walk with you." We observed one group activity referred to as, "Namaste." This was a program used for people with in either a group or one to one setting and provided sensory and meaningful activity to people using lights, music, food, textures, scents and colour to stimulate people. People were supported to take part in activities that were appropriate to their needs.

The manager developed a newsletter on a bi monthly basis which provided people and relatives with an update on what was happening in the home. There were also meetings that people and relatives could attend to provide feedback and raise concerns.

Requires Improvement

Is the service responsive?

People and relatives we spoke with told us they would be confident to raise their concerns or complaints with staff or management. A copy of the complaints policy was freely available for people to review within the home. We looked at the complaints records and saw that complaints that had been received were recorded and responded to within a set period of time. Where people were unhappy with the response of the manager, then they were able to refer their complaint to the providers head office. Guidance was available for people of organisations who could assist them with making a complaint, and also for people such as the ombudsman and Care Quality Commission.

Requires Improvement

Is the service well-led?

Our findings

People who used the service, the majority of relatives and all staff members thought that the home was well-led. They told us that the home manager was approachable and supportive. One person said, "[Manager] is a carer first and a manager second, they are always around to talk to, and I am happy to tell them what I think." One person's relative told us, "[Manager] is open, talkative, and responsive and I am sure they have the welfare of the residents at their heart." However one person's relative thought that their views and opinions were not listened to.

The provider had a range of systems in place to assess the quality of the service provided in the home. These included regular quality monitoring visits undertaken by members of the provider's senior management team and also a recent review by an external company on 20 and 21 July 2015. We looked at this recent audit and saw this was a check of the quality of service provided based upon five key questions. We noted that the audit had identified PRN records not used, kitchenettes and flooring requiring replacing, and a malodour coming from a carpet on Rowan unit, in addition to chairs that required cleaning and general redecoration. Furthermore we saw that some care plans had not been reviewed in June 2015. The manager demonstrated to us that they had acted upon the feedback from this audit, and had completed some of the actions from this. We saw that care plans had all been reviewed and were up to date, and redecoration had begun. We saw that the findings from the independent audit and providers audit had identified similar areas of concern, which suggested to us that quality monitoring systems were effective in identifying areas that required improvement.

In addition to audits by the provider the manager carried out their own monthly reviews of the quality of service provided. We saw they frequently audited areas such as medicines, environment and health and safety, care plans, incidents, staffing levels and staff development. An action plan was developed that identified areas for improvements. We saw from the last audit seen for June 2015 that areas such as care plans furniture and flooring had been identified as requiring improvement. In many cases actions that the manager was responsible for had been completed, however actions that required authorisation from the provider were left pending with no date for completion.

People's care records when reviewed did not always contain sufficient detail to provide a comprehensive account of a person's needs and care. We saw in people's monthly reviews that in many cases the same phrase was used month on month. This did not provide an accurate account of what areas had been reviewed and in some examples people's needs had changed, particularly with regard to people's behavioural needs. Daily notes were not descriptive and often stated facts for example, "Did not eat." But did not record what had been eaten, or why the person had not eaten or any attempts to encourage a person to eat. We spoke with the manager and senior manager about the quality of people's care records. They told us they were aware of some of the recording issues and were in the process of implementing a new care plan training program. This aimed to identify nine sections of planning, recording and reviewing that staff were required to follow. Each section had a template completed demonstrating to staff what information was required to be completed.

The manager undertook a wide range of audits, checks and observations designed to assess the quality of all aspects of the service delivery. These included areas such as medicines, care planning and delivery, health and safety, the environment, accidents and incidents, complaints, infection control and mealtimes. Information about the outcomes of these checks, together with any areas for improvement identified, was reported to the provider each month with details of actions taken and the progress made.

We reviewed a report of a quality monitoring visit undertaken in May 2014 by representatives from the local authority Adult Care Services. The home had achieved an overall score of 84.3% with no areas of serious concern identified. In the section for management and quality assurance systems the service had achieved 100%. Where areas had been previously identified, such as best interest decisions and DoLS assessments being completed, we saw the manager had taken appropriate action to resolve this.

A range of meetings were held in the home, not only for staff but also for residents and relatives. Minutes of these meetings showed us that a range of issues were discussed, and that people and staff could share their views and opinions about aspects of the quality of care people received. A questionnaire had been sent to people and their relatives in 2015 and the results had been analysed. Where concerns had been raised by people, the manager

Requires Improvement

Is the service well-led?

had developed a service action plan to address these concerns. One person's relative told us they did not feel the management team listened to their views about the home and care their relative received. We spoke with the manager about this, and they told us they had met with the relative concerned and had planned further meetings to address their dissatisfaction.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2) (h)** **People were not cared for in a clean environment.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.