Ranc Care Homes Limited

Orchard House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Orchard House is registered to provide accommodation for up to 64 people who require nursing or personal care. The home provides a service for older people, some of whom are living with dementia. At the time of the inspection there were 42 people living in the home. The home is on the outskirts of the town of Wisbech. The home has two floors with the Rivendell unit on the ground floor and Lothorian unit on the first floor. The first floor is accessible by a passenger lift or stairs.

This comprehensive inspection took place on 10 May 2017 and was unannounced.

At the last inspection on 11 May 2016 there was a breach of the legal requirements found. We found that improvements were needed to ensure that people were protected from harm through appropriate referrals to the local authority safeguarding team. The provider told us that they would take the required action by 31 July 2016.

During this inspection we found that the provider had made some improvements in relation to the previous breach. However, people were at a continued risk of harm because referrals to the local authority safeguarding team had not been made by staff in a prompt manner.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The registered manager was not present during this inspection.

Risks to people who lived at the home were identified. However, systems were not in place to assess and manage all risks to people. Staff understood some of the risks but not how to minimise them for people whose behaviour was at times challenging. Staff did not always treat people with care and respect or make sure that their privacy and dignity was respected all of the time.

Staff did not have the information they needed to administer 'as prescribed' medication. The provider's policy on administration and recording of medication had not been followed by staff. Audits in relation to medication administration had been completed but were not robust, as they did not always identify all areas of improvement required.

People had not always had their needs assessed and reviewed so that staff knew how to support them and meet their requirements. Some people's care plans contained person centred information which detailed people's likes and dislikes and how they wished to be supported but others did not.

There was a system in place to record complaints. However, these records had not always included the outcomes of complaints or how the information was to be used by staff to reduce the risk of recurrence.

People were not always supported to have maximum choice and control of their lives. Staff were trained but did not always understand the key principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) or how people were supported to make decisions if they lacked capacity. We saw that appropriate DoLS applications had been made to lawfully deprive people of their liberty. Authorisations in place were for people's own safety because they were unable to make decisions on where they should live safely.

People were not always kept safe because the number of staff on night duty did not tally with the staffing levels the provider had calculated was necessary to meet people's needs. The provider had a recruitment process in place and staff were only employed within the home after all essential safety checks had been satisfactorily completed. Staff received an induction when they started work and further training was available for all staff which provided them with the skills they needed to meet people's requirements.

People were involved as far as practicable, in how their care and support was provided. Staff monitored people's health and welfare needs and acted on issues identified. People were enabled to access health care professionals when they needed them. People were provided with a choice of food and drink that they enjoyed. People, where required, were given the right amount of support from staff to enable them to eat and drink.

People, relatives and staff were able to provide feedback and information However, this information was not always used to monitor and improve the quality of the service. The management did not always provide an open or fair culture.

Staff meetings, supervision and individual staff appraisals were completed regularly. Staff were supported by team leaders, deputy manager and the registered manager during the day.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's prescribed 'as required' medication was not always administered by staff who followed safe practices or the providers policy. Medication audits were in place and areas of these identified where improvements were needed. However, remedial actions had not been completed. This put people at risk of unsafe medicines administration.

Risks to people's safety and welfare were not always assessed and managed.

People were not always protected from harm because staff did not always follow the provider's procedure and make appropriate safeguarding referrals in a timely manner.

The recruitment process ensured that only suitable staff were employed to work with people they supported.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was making applications in accordance with the Mental Capacity Act 2005 (MCA) legislation to protect people's rights. However, staff were not knowledgeable about the application of the MCA when looking after people.

Staff were trained and supported to enable them to meet people's individual needs. However, people's individual mental and physical health needs were not always met to keep them well and comfortable.

People had enough to eat and drink and their dietary needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were often looked after by kind and attentive staff but care was not carried out in a consistent way.

People's rights to privacy and dignity were not always upheld.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual health and social care needs assessments were not always completed to ensure their needs were met. This put people at risk of receiving care that was not appropriate.

People's needs were not always kept under review to ensure their planned care was appropriate to their current needs.

People maintained contact with family and friends.

The provider had a complaints procedure in place so that people and their relatives could raise their concerns. These were not always responded to consistently or used to improve the care provided.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place.

The management did not promote openness and transparency.

Quality assurance systems were in place but these were not robust enough to ensure the quality and safety of people's care.

Orchard 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 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 unannounced inspection took place on 10 May 2017 and was carried out by three inspectors.

We reviewed previous Care Quality Commission (CQC) inspection reports and notifications received by the CQC. A notification is information about important events which the service is required to send us by law. We also looked at information we held about the home.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We reviewed the information to assist us with our planning of the inspection.

During the inspection we spoke with three people living in the home and two relatives. We also spoke with the deputy manager; one nurse; two team leaders; four members of care staff; the regional manager, and the provider's representative.

We spent time observing the care provided by staff to help us understand the experiences of people unable to tell us their views directly. This was because some people were living with dementia.

We looked at three people's care records, quality assurance surveys, staff meeting minutes and audits. We checked records in relation to the management of the home such as health and safety audits, three staff files and staff training records.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in May 2016 we found that the provider was breaching one legal requirement in this area and was rated as requires improvement. We found at this inspection that the provider had made some improvements to investigate and respond to allegations of harm.

Improvements had been made because we found in most cases that appropriate referrals to the local authority safeguarding team had been made. Since our previous inspection 17 referrals to the local authority safeguarding team had been made. However, we found one referral where the information provided to the local authority was incorrect. We also found another incident that had affected the health and wellbeing of one person had not been reported or dealt with appropriately or promptly to keep the person safe. This was because the referral was, "waiting for the regional manager to return" before the information was sent to the local authority safeguarding team. The regional manager was not due to return to the home for three days after the event. Information in the PIR showed that, "All staff are trained in safeguarding of vulnerable adults with ongoing refresher training annually. All incidents are recorded and adult protection and CQC informed." However, we found that that this was not always the case. This put people at risk and did not always ensure they were as protected from harm as they should have been.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Staff confirmed that they had undertaken training in safeguarding people from harm and were able to explain the process to be followed when incidents of harm occurred. One member of staff said, "There are different areas of abuse [harm] like emotional, physical, verbal or financial. I would report to the nurse in charge or the [name of registered manager]." The member of staff was also aware that they could report outside the home to social services or CQC. Another staff member said, "Abuse [can show itself through] behaviours that are unexplained, bruises, tearful or depressed. Reporting abuse is essential. I would do this – definitely." We saw that training records showed staff had received training in respect of safeguarding adults which was in line with the provider's safeguarding policies.

People were not always kept safe, because their physical and health risks had not always been recognised and the level of risk to people had not always been managed effectively. On Rivendell unit the information and areas of risk had been identified and managed to minimise the risks occurring. The areas included poor skin integrity, being at risk of falls and the use of equipment for moving and transferring people. However, on Lothorian unit, some risks had been identified but there was no information for staff on how to minimise the risks occurring. For example, we saw that two people displayed significant behaviour that was challenging to others; however there was no information on how staff should de-escalate situations or prevent them from recurring. This put the person, other people living in the home and staff at risk. The deputy manager confirmed to us that staff had not been provided with training in de-escalating situations where people were at risk.

We saw that one person's skin integrity was at high risk of their skin breaking down. There was no

information on the person's file for staff to know what they should do to reduce the risk occurring. We noted that another person had fallen on 3 May 2017 but their risk assessment had not been updated since this incident. One person was noted as being at risk of choking and needed to be supervised for eating and drinking. However, we saw that the person was walking around the unit carrying a box of biscuits and sweets and eating them without staff supervision. This meant that the person could have choked on the food they were eating.

On Lothorian unit we noted that some people's medications needed to be administered 'as required'. However, we found 'as required' medications did not always have protocols in place so that staff knew when these should be used. Where protocols had been written staff were unaware of them and therefore they had not been followed. We found that two people were given 'as required' medication to make them feel calmer and another for sleeping. However, their care records failed to show how staff should deal with situations before the need to have the medication administered. One staff member told us that they administered the 'as required' medication before providing personal care to calm the person. This was even though at that point the person had not displayed any agitation or behaviour that challenged. This meant people were administered 'as required' medication by staff who did not know how and when the medication should be administered.

We saw information in the care plan of one person on Lothorian unit that staff should monitor medication side effects but there was nothing that indicated what medication or what side effects. An internal audit completed in March 2017 stated, 'PRN (required medications) protocols in place do not accurately reflect the medication prescribed.' This action point was signed off as completed, but there was not date of completion documented.

Staff said, and records showed, that they had undertaken the necessary on-line training in medication administration. Information in the PIR showed that there had been four medication errors and one where medication was not available for six days.

This meant people were not protected from staff because staff had not followed the provider's policies and procedures in medication administration.

This was a breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We observed how staff administered medication on Rivendell and saw that this was in line with the provider's procedures. On Lothorian we checked to reconcile the number of tablets available to people and found they were correct.

The PIR showed that the community pharmacist had provided face to face training for all team leaders and registered nurses as a result of the errors. Staff confirmed that the training had taken place or would be undertaken next week.

We saw that there was a sufficient number of staff to meet the needs of people using the service during the day. However, information from the dependency system used in the home, (this is a system used to determine safe staffing numbers per shift) dated 1 March 2017 showed that there should be one nurse, one team leader and four care staff working at night. The rotas we saw showed that over the 14 nights in April 2017 there were no nights when the home had this number and the appropriate skills mix of staff working. This meant people could be at risk because staff were not available to meet their needs. Discussion with the provider's representative was that the staff duty rotas were not always accurate and therefore there may

have been agency staff that had not been recorded. However, there was no robust documented evidence that could be provided at the time to confirm this.

People and their relatives told us they felt safe. One relative commented, "I am absolutely confident that staff care is as good when I am not here." The relative went on to say that they visited at different times of the day and had always found their family member safely cared for.

We saw that there was a policy in place in relation to recruitment. We saw that staff only commenced working in the service when all the required recruitment checks had been satisfactorily completed. Staff told us that they had provided a number of documents which included an application form, a disclosure and barring service criminal records' check and references. This meant that there were checks in place to make sure that only suitable staff of a good character worked with the people they provided a service to.

Requires Improvement

Is the service effective?

Our findings

We checked to find out if people were being looked after in a way that protected their rights. We found that the provider was not always ensuring that people's rights were respected in line with the Mental Capacity Act 2005 (MCA). 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 their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

In their PIR the provider stated that 58 members of staff had received training in MCA and DoLS. However, we received a mixed response from staff in relation to how people's rights were being protected. They were unable to consistently demonstrate sufficient knowledge about the Act and its key principles. As a result we were not confident that people's rights were being fully protected. This was because staff were not aware of how the Act impacted on people, how information should be recorded to check people's best interests or the areas that they may or may not have capacity over. For example, one person who had been deemed to lack capacity had bedrails agreed by their family. There was nothing recorded to show that bedrails were in the person's best interest. There was information that a number of care plans in relation to people's capacity to consent for example to have medication administered needed to be completed. We saw that one person had a diagnosis of dementia and did not have capacity to make decisions about their safety or medication administration. However, there was no best interest decision recorded.

We spoke with one authorising authority who stated there were 41 applications for DoLS from Orchard House awaiting authorisation. The information provided about people's assessment of mental capacity was minimal and often lacked thought about people as individuals and their needs and restrictions. Information in the PIR showed that one DoLS application had been authorised. The registered manager had confirmed before the inspection that referrals had been made to the appropriate agencies to carry out DoLS assessments for other people. Information about Independent Mental Capacity Assessors (IMCA's) was displayed on notice boards. This was to help those people or families who may wish to request external help and information. This is as well as IMCA being a voice for people who had no other representative than paid staff to advocate for the person.

The provider told us in their PIR, "We encourage healthcare professionals [from outside the home] to train staff [inside the home] and ensure staff are kept up to date with any new legislation and regulation. Recently we had the Tissue Viability [nurse] in to demonstrate new wound dressings." A newly appointed member of care staff said that they had completed induction training. This included being, "paired up with an

experienced [member of] staff." Other staff members told us that they had completed training on line (computer). Information showed that challenging behaviour, dementia awareness, medication and infection control had been completed by over 70 per cent of staff. Most staff had completed their practical moving and transferring training. There was a training plan in place which identified when staff needed to complete the updates for on-line courses. This meant that people were being looked after by staff who had received some training to support and meet the needs of people living in the home.

Staff told us that they had attended face-to-face supervision sessions and records showed that this was the case. One member of care staff said, "Supervisions are for me to say [what works well] and any support [I need]." Staff told us there were, "regular supervisions every six months," although one member of staff told us they had not had supervision since September 2016. Staff said that they felt well-supported and worked "to help each other" and "work well as a team."

We checked to find how people's nutritional health was met. People on Rivendell unit told us that they had enough to eat and drink and said that they liked the food. We saw that there was fresh fruit and a variety of drinks available for people. On Rivendell unit one person told us that the food was "marvellous" and they got a choice of what they wanted to eat and drink. The person went on to say that staff were helping them to maintain a healthy weight. We saw people were offered drinks and snacks during the day. We observed that people were assisted to eat at a comfortable pace and staff checked to ensure the person had swallowed the mouthful before attempting to give them another. One staff member working on Rivendell unit said, "People can choose their meal the day before. They can have an alternative. We go around at about 2:30 pm and ask people what they want for tea. Also we use signs and pictures [visual prompts], for people who needed it, or [they were shown] a plated meal to help them choose." On Rivendell unit we saw that food and fluid charts had been completed where necessary.

On Lothorian unit we observed how people were treated during the lunchtime. One person was asked which choice for the main course at lunchtime. There were no picture menus although there had been a discussion at a previous staff meeting to use them. This was so that people living with dementia could see what was being spoken about and on offer. We saw that people were waiting up to 25 minutes for their dessert. Staff were unable to tell us why the desserts were not immediately available. The impact on people who are living with dementia is that they can become agitated or leave the table because of their level of concentration or lack of understanding of the delay.

People's individual dietary needs were catered for. We saw that where necessary people had thickened fluids and food with appropriate guidelines. Soft and pureed foods were available for people who had difficulty with swallowing. People who were at risk of unintentional weight loss were offered fortified foods (calorie rich) and nutritional supplements and staff were aware of who required this additional support. One relative told us, "[Family member] has an excellent appetite and eats everything. They have just been given custard with thickener."

We saw evidence that people living in the home had access to relevant health professionals such as dietician, speech and language therapist (SALT), tissue viability nurse (TVN), falls team and GP as well as access to services such as hairdresser, chiropodist, optician and dentist. People's records and what people told us showed that this was the case.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they were very happy with the staff and the care they received. However, we saw that people were not always cared for in a kind and compassionate way by staff and that people's privacy and dignity was not always respected.

Information by the provider showed that staff were "trained on induction to knock on people's bedroom doors and have a respectful manner" to the people living in the home. We saw that staff on Rivendell unit knocked and waited to enter people's bedrooms with the person's permission. However, one person who wanted to discretely leave the living room was unable to do so when staff shouted out where they were going. This meant the person was not provided with dignity or respect they deserved from staff.

On Lothorian unit, where people are living with dementia, although staff told us they knocked on people's bedroom doors "out of courtesy", we saw several members of staff walk into people's bedrooms without knocking or introducing themselves. We heard how one person was spoken to by a staff member and told, "You'll have to wait I'm busy." On another occasion we heard a person told by staff to go and sit in the lounge because there was no chair in the office. The person became more agitated but was still told to go into the lounge. The staff member told us that there was no chair, but had not made any effort to get one for the person or to reassure the person. We informed the deputy manager about these issues at the time of the inspection and they told us that these concerns would be acted upon.

Most people had care plans that identified how they wanted their care to be provided. On Rivendell unit one member of staff told us, "We get to know people by going through the care plans with an experienced staff member." We saw a 'life map' document. This was a document to help people living with dementia by providing prompts for them to remember important events such as family birthdays and recognise hobbies they had taken part in and enjoyed previously. One person told us, "I watch TV and hear okay. I can request a programme to watch [in the lounge]." We saw how staff supported people when they needed help and staff knew people's likes and dislikes.

On Lothorian unit information about what was important to people and how to support them to be "happy, safe and knowing they were cared for" was not always recorded. For example the file of one person stated 'not applicable' in relation to expressing their sexuality, and no to 'how does the person express their own sexuality'. This meant people may not have been cared for as they would wish.

End of life care had not always been discussed or completed in people's files. We also saw information on one file that would be confusing for staff in the event the person requiring resuscitation. This was because their file contained a 'Do not resuscitate' form at the front of the file, only to have other information that indicated the person should be resuscitated or sent to hospital in the event of a cardiac arrest. This meant that people may not be provided with the care that they wished for as well as being provided with care that was not appropriate.

One person told us, "It's marvellous; everything is as it should be. Everyone is so pleasant. I love living here. I

am settled." Another person said, "It's much better now it's my home." Whilst a visiting relative told us, "They [staff] are very, very caring and respectful. The best staff I have come across. Nothing is too much trouble." We saw that relatives' or friends' visits could be at any time people wanted. People were enabled to maintain contact with their friends and relatives. One person said, "My [family member] visits frequently and whenever he wants. There are no problems [time limits] for visitors." One relative said that there were no restrictions on when they could visit and often came at different times and days.

The regional manager showed us that details of independent mental capacity assessors was displayed in the foyer. Details of other advocacy services could be provided should people want them. Advocacy services are independent and support people to make and communicate their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

Information in the PIR showed that 'prior to admission all prospective service users have a complete pre admission assessment this will include involvement from the family if the service user does not have capacity or agrees. This information is used to develop a full picture of the service user's care. We evaluate the plan of care."

Although some people told us they were involved in their assessment of care we found that people living with dementia had less information available for staff to ensure their needs were met. In one file on Lothorian unit we saw that the person's care plans had not been fully completed in areas such as continence or bathing and did not show what support the person needed from staff. For example, in relation to personal care the information was, "(Person's name) needs support in all areas of personal care with one member of staff. Needs help and will let the staff help but can get distressed at times." There was no information for staff about what the person could do independently, what support the staff should provide or what to do if the person became distressed. This put people at risk of receiving care that was not based on accurate or up to date information.

The provider told us in their PIR, "We evaluate the plan of care for each area monthly or as and when required. Relatives have the opportunity to be involved with the plan of care six monthly or annually." However, we did not find that care plans had always been reviewed as stated. We saw that in one file in Lothorian unit, areas that should have meant the person's care and wellbeing, such as maintaining a safe environment were reviewed, were not completed. In another person's file on Lothorian unit it showed their medication care plan had not been reviewed since October 2016. This meant that there was an increased risk that people were not always cared for by staff who had the necessary information they needed.

Staff told us information was shared, so that they were kept up-to-date about changes in people's needs. For example, one member of staff told us there was a daily handover meeting where staff were updated in relation to people's changes in areas such as medication and people's general wellbeing. This meant that relevant health or care information was handed over to staff coming on to shift and the information about any changes to people's care was discussed but this was not updated onto people's care plans or risk assessments.

During our inspection we found that on Rivendell unit people were encouraged and supported to take part in activities, which on the day of inspection included bingo. However on Lothorian unit information about people's interests and hobbies had not been completed and therefore staff would not have the necessary information to provide interesting or appropriate activities. One relative told us they had seen recently seen people taken out into the garden and that a pet therapy dog had visited the home. There were details of future events planned such as 'zoo lab' (different small animals and other creatures), church services, a play put on by an outside acting production, music from 'banjo man' and puzzles. The home will be involved in the 'Care Home Open Day' which is an annual event to promote links with the community and any people interested to learn about the home.

People were aware of who to speak with if they wanted to raise a concern or complaint. The provider wrote in their PIR, "The management has an open door policy and will meet with service users and relatives to discuss any issues they may have. There is a complaints system in place and all issues are fully investigated." One person said, "I would get in touch with [the head office] if I needed to." We checked to find how the provider responded to any complaints raised. We saw that the provider had recorded complaints but had not always dealt with them consistently. As a result the information had not always been used to improve the home. We did find an example where staff had been provided with a system of observation when people were unable to call for help. We saw that a copy of the investigations, which had been undertaken by management in the home, had been sent to the complainants. This meant that people could be assured their complaints would be investigated.

Requires Improvement

Is the service well-led?

Our findings

We checked to find out how the home was being managed. There was a registered manager in post but they were not in the home at the time of the inspection. The registered manager was supported by a deputy manager, nurses, team leaders, care staff, regional manager and provider's representative.

The provider aimed to operate an open and transparent culture. In their PIR they wrote, "The [registered] manager has an open door policy and ensures all staff are treated fairly, transparently and with respect." However, our discussions with staff evidenced that this was not always the case. Staff told us they lacked confidence to approach management as they did not feel they would be treated fairly or with respect. This showed there was a lack of openness, which would have ensured a positive culture within the home. The provider's representative was aware of the issues and challenges and steps were being taken to address them.

Internal audits completed on 13 and 20 March 2017 showed that an action plan had been put in place in relation to a number of issues identified. Although the actions to be taken were recorded and signed off as complete we found improvements, such as protocols for 'as required' medications to be in place, were still needed when we checked during this inspection. This meant that the provider's quality monitoring system was not always robust or thorough enough to monitor and drive forward the necessary improvements needed. This also limited the provider's ability to respond to situations as quickly and effectively as they could have.

Food and fluid charts had been completed to show the amounts people were eating and drinking. However, repositioning charts had not been completed in line with the frequency guidance on the form. This had been recognised as an issue in the audit of 13 and 20 March 2017 and discussed with staff at group supervisions. The action to be taken was noted as, 'there is now resident allocation in place so team leaders and Registered Nurses can identify who has not completed the charts correctly'. However, audits were not completed on the day to check that repositioning was being undertaken. For example, we saw that one person was to be repositioned every three hours. The person had between four and five hours, and on one occasion eight hours, between repositioning. This meant people could be at risk of their skin integrity breaking down. Audits and quality assurance processes had not identified this continued omission.

The provider had investigated whistle blowing concerns. Staff were aware of the whistle blowing policy and procedure and said they would report any poor practice if they needed to. One member of care staff said that they would be confident to whistle blow without any repercussions.

People and relatives on Rivendell unit knew who the manager was. One relative said, "[Name of registered manager and a nurse] are fabulous, so caring."

People, their relatives and staff were consulted about the quality of the care and support provided to people. Surveys had been sent out and collated in February 2017. The information received from people, their relatives and staff had not been used to formulate an action plan based on the outcome of the surveys.

For example, people or their relatives commented on the lack of activities, management not available at the weekend and that menus were not available at mealtimes. However, we found that changes had been made and menus were available at mealtimes, the deputy manager said she had been in every weekend since she started in April 2017 and new staff had been employed to improve the quality of activities for people.

There were other ways people could have the opportunity to comment about the home. The provider told us in their PIR, "Regular meetings are held with all [residents and] relatives to keep everyone informed of any changes and ensure there is good communication." Minutes of these were seen. There were discussions about a number of subjects raised by people, such as fresh fruit in the lounge, going out into the community or use of the downstairs dining room being used more. There was evidence that action had been taken or in the process of being undertaken in relation to the discussed areas. Examples of improvements included where we saw that fresh fruit was now available in the lounges for people to help themselves.

Staff said there were regular team meetings such as heads of department, care staff, group supervision, mini unit meetings and activity meetings. We saw a number meeting minutes. The minutes for the activity team for 12 January 2017 discussed commencing a survey of the people and the activities they would like to be involved in, improving the cinema room use and promoting film afternoons as well as discussing theme days with the catering team. There had been a care staff meeting on 26 April 2017. The discussions were about training to be completed, staff to be polite and courteous, not to make 'throwaway' comments that could be overheard by other people, food and fluid charts must be accurate and resident of the day to be introduced 3 April. March 2017 unit meetings discussed spot checks on night staff and charts to be completed such as food, fluid and repositioning. This showed that the meetings were also used as a forum to ensure that staff understood their responsibilities and what was expected of them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not kept safe because risks had not been assessed or managed effectively. People were not kept safe because there were no protocols in place for medication that should have been administered 'as required'. Regulation 12 (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Although appropriate systems and processes were in place, staff had not followed the provider's procedure in protecting people from harm. Regulation 13 (2)