Mayflower Care Homes Limited

Hillgrove Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was comprehensive inspection carried out on 24 and 26 October 2017. Hillgrove Residential Home provides accommodation with personal care for up to 23 people. Nursing care is not provided. At the time of our visit, 22 people lived at the home.

The home is a detached house set in its own grounds in the area of Bidston, Wirral. There is a small car park and garden with seating available within the grounds. Accommodation is provided on three floors with a passenger life enabling access to bedrooms on the first and second floor. All bedrooms are single occupancy and have a wash basin. There are communal bathroom facilities on each floor. There is a communal lounge, a lounge/dining room and a quiet lounge for people to use.

At the time of inspection there was a registered manager in post. 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.'

The home's installations and lifting equipment had all been tested and certified as safe. For instance gas, electrics, hoists, fire alarm and the passenger lift. We found however that other parts of the home were in need of repair or were unclean. For instance, some of the home's fire doors were faulty which meant they would not offer the required protection in the event of a fire. Some rooms did not have access to water sufficiently hot to enable good hand hygiene. Some of the home's light fittings were broken and some of the plug holes in people's hand basins were covered with limescale. This meant that the parts of the premises were unsafe and unclean.

Other improvements to the standards of infection control were also needed. We found some people who were sharing a bedroom also had shared hand towels or bars of soap. This was not good practice. People in shared accommodation should have their items clearly marked for their own personal use in order to prevent the spread of infection. We spoke with the manager about this. They assured us that all shared items would be removed. Systems were not in place to monitor and manage the risk of Legionella bacteria and the risk of this developing in the home's water supply had not been assessed. We spoke with the manager about this and shortly after our inspection we received confirmation that a Legionella risk assessment had been organised.

Staff were recruited safely but some of the criminal conviction information relating to staff members may have been out of date. This was because some staff had been employed for over ten years without this information being renewed. Staff records showed that staff had adequate supervision in their job role but we found limited evidence that staff had received an appraisal of their skills and abilities or sufficient training to do their job role effectively. This meant the manager could not be confident that the skills and knowledge of staff members was sufficient or up to date.

We found that improvements to the way the home was managed were required. This was because the audits conducted by the manager in relation to health and safety, maintenance and infection control failed to identify and address the issues we found during our inspection. Similar issues in relation to health and safety, maintenance and infection control were also identified at the last inspection. This meant that the manager had been made aware previously that these areas required improvement but had failed to take sufficient action to address them. Other audits completed by the manager were either generic or not always accurate. This meant they were meaningless.

The home has been rated 'requires improvement' because of these issues. This is the second time the home has been rated requires improvement.

There were however lots of positives about life at the home that showed other aspects of good leadership. We spoke with four people who lived at the home and four relatives during our visit. Everyone we spoke with was positive about the home. It was clear they were happy with the care provided by staff. People told us the staff were kind and caring and our own observations of people's care confirmed this.

There were enough staff on duty to meet people's needs and people told us they got enough to eat and drink. They said the food was good and they had a choice. We saw that people's weight was monitored regularly to ensure they maintained a healthy weight.

People's care records were person centred and contained information about their needs and preferences. Information about what people could do independently was identified and staff had guidance on how to support people to remain as independent as possible.

Some people had short term memory loss that impacted on their ability to make decisions.
We saw elements of good practice in relation to the implementation of the Mental Capacity Act 2005 (MCA). For instance people's capacity had been assessed for some of the specific decisions made about their care. Best interest discussions had been held and people had access to independent advocacy as and when need. This ensured people's views and wishes were fairly represented. People's capacity was not always assessed in relation to decisions to deprive them of their liberty and we spoke with the registered manager about this. They assured us they would review this without delay.

Activities were provided to occupy and interest people and on the days we visited we observed people enjoying a group quiz and a ball game. We saw that staff took the time to sit and chat to people in addition to meeting their support needs. This promoted their well-being. All of the interactions between people and staff were positive and the home had a warm, homely atmosphere. Staff we spoke with demonstrated a good knowledge of people's needs and were able to tell us about people's preferences and likes and dislikes. This showed us that staff knew people well. The culture of the home was open and transparent and it was obvious that people felt content with the support they received.

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.

Parts of the home were in need of repair or were unclean. Infection control standards and the home's fire safety arrangement required improvement.

People told us they felt safe and had no worries or concerns.

People's risks were identified and staff had guidance on how to provide safe and appropriate care.

Staff were recruited safely and there were enough staff on duty to meet people's needs

The management of medication was safe and people were given the medication they needed.

Is the service effective?

Requires Improvement

The service was not always effective

Some staff had not received sufficient training to do their job role effectively or had an appraisal of their skills and abilities.

Mental capacity assessments were undertaken for some decisions made in relation to people's care but the assessment of some people's capacity did not comply in full with the Mental Capacity Act where a DoLs had been applied for.

People said they were well looked after. They said they were given enough to eat and drink and were given a choice.

People's needs were met by a range of healthcare professionals to maintain their well-being.

Is the service caring?

Good

The service was caring.

People and the relative we spoke with told us that staff were kind and caring. Our observations of the service confirmed this.

Staff chatted socially to people and these interactions were warm and natural. It was clear that people and staff knew each other well and had developed positive relationships with each other.

Regular residents meetings took place and people were able to express their views about the day to day issues that were important to them.

Is the service responsive?

Good

The service was responsive.

People's care was person centred and responsive to their needs. People were smartly dressed and looked well cared for.

People had access to social activities to promote their well-being.

The provider's complaints procedure lacked clear information on who to contact in the event of a complaint. No-one we spoke with during our visit had any complaints about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A range of quality assurance systems were in place to monitor the quality and safety of the service. The systems were ineffective and did not mitigate risks to people's health, safety and welfare.

A satisfaction survey was available but its organisation was ad hoc and a representative view of people's feedback was not gained.

People and their relatives were happy with the care provided and spoke highly of the staff team. This showed that the day to day care provided by staff was well-managed.

The manager and deputy manager were responsive and demonstrated a positive commitment to continuous improvement.

Hillgrove Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 24 and 26 October 2017 and was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection in October 2016. We also contacted the Local Authority and the NHS Infection Control Team for their feedback on the home.

During the inspection we spoke with four people who lived at the home, four relatives, a visiting healthcare professional, the registered manager, the deputy manager and four care staff. Some people had communication difficulties due to declining mental health. This meant they were unable to talk to us. We used the Short Observation Framework Tool (SOFI) which is a specific way of observing care to help us understand the experience of those who could not talk to us.

We looked at the communal areas that people shared in the home and visited a sample of their individual bedrooms. We looked at a range of records including four care records, medication records, three staff personnel files, staff training records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We spoke with four people who lived at the home. All of the people we spoke with said they felt safe at the home and were well looked after. Relatives we spoke with agreed with this and felt their loved ones were happy at the home.

Records showed that regular tests had been carried out on the safety of the home's electric, gas, fire alarm system, passenger lift, hoists and portable appliances but we found other parts of the building and its equipment were unsafe or unclean.

For example, the fire door leading into the kitchen and laundry areas had dropped and would not close automatically as it was wedged to the floor. The fire door leading into the quiet lounge on the ground floor did not close properly automatically, a bedroom fire door was propped open with a bedside cabinet and one of the upstairs fire doors did not have fire retardant intumescent strips. This meant that the home's fire doors would not provide the correct level of protection in the event of a fire occurring. There was a problem with the hot water supply to some outlets. One person's hot water tap in their bedroom did not work at all and some of the hot water taps in other people's bedrooms did not run water hot enough to ensure good hand hygiene and infection control. The temperature of the water must also have been unpleasant for people to wash in.

We asked to see evidence that water temperatures were monitored and adjusted were necessary to prevent the risk of Legionella developing in the home's water system. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. A provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. We found that this risk had not been assessed by the provider and records showed that no routine checks of the temperature at which water was stored and dispensed had been completed since September 2016.

We saw that parts of the home had been refurbished. For instance there was new flooring in the communal lounge, new chairs and blinds had been purchased and a new electrical box had been fitted. The manager told us that roof repairs were due to be undertaken and we saw that there were dried damp patches in parts of the home to indicate this work was necessary. Other areas also required improvement. For example, in a bedroom that was shared by two people only one person's bedroom light worked, one person's wardrobe had a handle missing of the door and one of the window frames in a downstairs bedroom was rotted which meant the window would not close properly. One person's headboard was wobbly and a light fitting in the communal lounge was broken.

Some areas of the home were unclean. We saw that one person's commode seat cover was ripped exposing the inner sponge. This would have made the commode seat difficult to clean and presented an infection control risk. Plug holes in some people's hand basins were marked with limescale or looked corroded and the sink in the laundry was dirty. The communal shower room had a sponge in situ and some of the bedrooms that people shared contained shared items such as hand towels and bars of soap. Sharing personal items such as hand towels and sponges places people at risk of the spread of infection.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the premises were safe and infection control standards maintained. The domain of 'safe' has been rated 'required improvement' because of this. This is the second time this domain has been rated requires improvement.

We spoke with the manager about the issues associated with the premises and infection control practices. We drew to their attention that similar issues were identified at the previous inspection. They told us they were in the process of recruiting a new handyman to sort out these issues. They said they would remove all shared items from people's bedrooms. Shortly after our visit, we also received confirmation that a legionella risk assessment had been organised.

We looked at the care records belonging to four people who lived at the home. Care records were in the majority electronic and stored on a computer. We saw that risks in relation to people's care were identified and that staff had suitable management plans in place to advise them how to manage these risks in the day to day delivery of care. Risks in relation to mobility, falls, nutrition, pressure sore development and mental health were all assessed and managed. Records showed people received the care they needed to keep them safe and well.

There were personal emergency evacuation plans in people's electronic files but there was no adequate 'grab' file for staff and emergency services to use in an emergency situation. This meant that should an emergency occur then staff would have to try and access a computer to print off information that may be vital in assisting emergency personnel to evacuate people to safety. We spoke with the manager about this and they said they would address this without delay.

We saw that accident and incident records in relation to falls were completed properly but these records had not always been signed off by the manager to show that they had been reviewed. We saw that the manager completed a monthly audit on the number, type and location people's falls to monitor the number of accident and incidents each person had. This enabled the manager to take appropriate action when people required extra support to keep them safe. For example by a referral to the falls prevention team.

We observed the administration of medication and saw that it was safe. Medication records were completed accurately. We checked a sample of people's medicines and found that the stock of medication matched what had been administered. This indicated that people had received the medication they needed. The temperature at which medication was stored was monitored daily and medication was stored securely. We saw that staff responsible for administering medication had been trained to do so.

During our visit the number of staff on duty was sufficient to meet people's needs. People and the relatives we spoke with confirmed this. The atmosphere at the home was relaxed and homely and people's needs were met in an unhurried manner. We looked at staff recruitment files and found that staff had been recruited safely. Pre-employment checks such as previous employer references, a criminal conviction check and proof of identification had all been sought prior to appointment. We found that the criminal conviction information for some staff was over ten years old. This meant there was a risk it was out of date.

We spoke with two staff members about safeguarding people from the risk of abuse. Both staff members demonstrated an understanding of the types of abuse and the action to take should any potential abuse be suspected.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that they were happy with the support they received from staff and one person said staff were "Very good to us". Relatives we spoke with spoke highly of the staff team. Their comments included "Staff are as good as gold"; Staff are very nice, they are all nice" and Staff are "Second to none".

The manager and care staff we spoke with knew people well. They were able to tell us about people's needs and care and spoke with genuine affection about the people they cared for. During the day we observed positive, warm relationships between staff and the people they supported. It was obvious that staff and the people who lived at the home knew each other well and were content in each other's company.

We looked at records relating to the training and support of staff. We found that staff had received regular supervision but there was limited evidence that their skills and competencies had been appraised. We spoke with the manager about this. They told us that staff appraisals were undertaken during a routine supervision meeting but acknowledged they were unable to demonstrate this.

Staff training records showed that training in moving and handling, safeguarding, health and safety, fire awareness, infection control, dementia care, mental capacity and deprivation of liberty safeguards was available to staff. From the training records we were provided with it was difficult to tell what the provider's mandatory training was. The manager was also unable to offer an adequate explanation. Staff training records showed that some staff had completed some of the training whereas others had not. There were gaps in staff training for all staff members, some staff training was out of date and some staff had not had sufficient training to do their job role effectively.

For example, one staff member had commenced in employment in January 2017 but records showed that they had only completed training in moving and handling. Out of the 12 staff members, eight staff members had not completed training in health and safety, five had not completed training in the safeguarding of vulnerable adults and three staff members had not completed training in dementia care, mental capacity, fire safety, first aid or food hygiene. This lack of adequate training placed people at risk of receiving inappropriate and unsafe care.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure staff had received an adequate appraisal of their skills and abilities and appropriate training to do their job.

The people we spoke with told us they got enough to eat and drink. They said they were happy with the quality of the food provided and were given a choice at mealtimes. People's comments included the food is "Very nice" and "We had a very nice one (meal) the other day" and "Corned beef hash was very nice".

We saw that people's weights were monitored and where people were at risk of malnutrition, this risk was well managed. Where people had special dietary requirements, their care plans contained sufficient information on what these requirements were and how to support people in accordance with their

preferences. This information was also provided to kitchen staff to enable them to prepare people's meals and drink in accordance with their dietary needs and preferences.

We saw that most people sat in the dining room to eat their lunch. It was busy but a warm and pleasant environment in which to eat. We saw that people were sat companionably together and people's meal looked and smelt good. The atmosphere at lunchtime was relaxed and homely and people were able to enjoy their meal in an unhurried manner.

The Mental Capacity Act 2005 (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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We looked at people's care files and saw evidence of good practice in relation to how the service ensured people's consent was sought. It was clear that the service had considered the Mental Capacity Act 2005 and associated code of practice when planning people's care. We saw that records showed that people's capacity had been assessed for some decisions and best interest discussions held where their capacity was in question. People and their families received support from mental health professionals, social services and legal advocates when any best interest decisions were made. This was good practice and ensured people's views and wishes were fairly represented when decisions about their care and welfare were made.

We found however, that decisions to deprive people of their liberty had not always followed the mental capacity act legislation. For instance some people's capacity had not been assessed prior to an application to deprive them of their liberty being made to the Local Authority. We asked the manager about this. They explained that in most of these cases, people had lived at the home for a while and that they had assessed their capacity at the time of their admission. They acknowledged that they had not necessarily completed a new capacity assessment when a deprivation of liberty safeguard became a necessity. They told us that they would ensure that this process was followed in future.

Where people had become unwell, we saw that prompt access to their GP had been organised to ensure that people received the medical care they needed to maintain their health. People's care records showed that they received support from a range of health and social care professionals such as mental health teams, dieticians, district nurses, podiatry and opticians. We spoke with a visiting healthcare professional on the day of our visit. They told us that staff friendly and were very prompt in reporting any issues to them with people's care. They told us however that staff did not always consistently follow the advice given to them and sometimes required reminding to do so.

The home's environment was pleasant but not really dementia friendly in order to support people who lived at the home with dementia to remain as independent as possible. There was some signage on communal doors for example, the shower room and lounge to indicate what these rooms were but other signage throughout the home was limited. For instance, people did not have any identifiable features on their bedroom door to enable them to easily identify which bedroom belonged to them. Being able to identify doors is critical for way-finding. The majority of the walls were decorated in magnolia and communal bathrooms were mainly white. The use of contrasting colours such as different coloured doors or walls or

contrasting toilet seats and handrails, have been shown to be effective in helping people to recognise and differentiate different objects and areas of the home in order to make sense of their surroundings.

We found some of the flooring in communal areas sloped with no adequate signage to warn people about the change in footing. One of the communal lounges also contained a heavily patterned carpet. People who live with dementia may find this confusing as they can sometimes interpret patterns in the carpet as holes or steps.

Good

Is the service caring?

Our findings

People we spoke with said staff were kind and caring. One person said ""Here's the wonder girl" (about one staff member) and told us staff looked after them well. We observed staff interacting with people who lived at the home and we saw that they chatted to people about the everyday things, people talk about when they know each other well. This supported people's wellbeing. Conversations between staff and people were spontaneous and it was clear that people were comfortable and relaxed in the company of staff.

Relatives we spoke with held staff in high regard. One relative said "Nothing is too much trouble" and that they were "More than happy" with the care their loved one received from staff. A second relative told us "They had always got time for them (the person)". People's relatives visited at various times during our visit and were treated with respect and consideration by all staff members.

We saw that people looked smartly dressed and well cared for. One relative told us that staff had made sure that the person's hair and nails were done and that the person had "Looked amazing" from the day they had moved into the home. This showed that staff cared that people received support with their personal care so that their dignity was maintained at all times. We heard staff giving people positive feedback and encouragement such as "You look beautiful" and "Brilliant" when supporting people with their mobility.

We saw that people were able to mobilise freely about the home and that they enjoyed sitting in the communal lounge, chatting with others or watching television for most of the day. When people became agitated or upset, we observed that staff responded immediately to offer support and reassurance and we observed that people responded positively to this support.

People's care plans outlined the tasks they could do independently and what they required help with. This helped to promote people's independence. Care plans gave staff sufficient information on the things that were important to people, their likes and dislikes and social interests. This type of information helps staff to develop caring and meaningful relationships with people. Some people's care files also contained evidence that independent mental health advocates were involved in people's care. Advocates support people to access information and make informed choices about various aspects of their lives. This showed that the service cared about ensuring people felt involved and in control of their care as much as possible. People's care records were stored and maintained on a secure electronic care system that staff could access to input information about people's day to day care. A computer was available in the office for staff to use. The system was password protected which ensured that people's personal information was kept confidential.

The manager told us that a resident/relative meeting was held regularly and records confirmed this. We looked at the resident meeting records for August and September 2017. We saw that the day to day issues that were important to people were discussed and agreed upon. For example, people's opinions on the food and activities on offer were sought. Records showed that where people had made suggestions, these had been acted upon. For instance, some people had asked for a certain type of meal to be provided such as a roast dinner or scrambled egg and we saw that after the meeting the manager had informed the cook to ensure people's suggestions were acted upon.

Good

Is the service responsive?

Our findings

People's relatives told us that staff always ensured people's needs were met and kept them informed of any changes in people's well-being. One relative told how staff had supported the person to be more mobile, maintain a healthy weight and had given the person "Great assistance".

Another relative told us it was nice to see "Them (the person) being happy" and that they had not expected them to be so, after recently moving into the home. They said staff had made the person's transition to the home a positive one and had been "Great at distracting" the person when they had become distressed. They told us this had helped the person settle into the home quickly.

We saw that group and one to one activities took place regularly. The home employed an activities co-ordinator and we saw they worked hard to ensure everyone was able to join in. One relative told us the activities co-ordinator did a "Hell of a job". On the days we visit, people enjoyed a group quiz and ball games. There was also soft music playing in a sitting area in the communal corridor and a quiet lounge for people to use upstairs for some solitude or for some privacy with their visitors. We saw that a singer had been booked to entertain people in September and that one person's birthday was currently being planned for.

People's needs were assessed before they were admitted to the home. This enabled the manager to be assured that the home was a suitable place for the person to live and that staff could meet the person's needs before they moved in. People's assessments considered all aspects of their individual circumstances such as their dietary, social, personal care and health needs.

People's care plans were person centred and contained information about their day to day preferences so that staff could ensure they were respected. For example, there was information about people's preferred daily routines, dietary likes and dislikes and how they liked their personal care support to be provided. People's care had been reviewed monthly to ensure that the support provided remained appropriate to their needs and staff completed written 'daily' reports of each person's progress so that up to date information about the person's well-being was available. People's daily records showed us that people's care was provided in accordance with their wishes and preferences.

We looked at the provider's complaints procedure and found that it lacked clear information on who people could complain to if they had concerns about their care or the care of a loved one. For instance, people were directed to make complaints direct to the manager of the home in the first instance, but failed to provide the manager's name or contact details. There were also no contact details for the provider, the local authority complaints department or the local government ombudsman to enable people to direct their complaint to should they remain dissatisfied. The complaints procedure therefore required improvement.

Some of the people who lived at the home lived with communication difficulties. This meant it may have been difficult for them to understand or remember how to make a complaint. We saw that where this was the case, the manager had ensured that information on how to make a complaint was given to the person's

family or legal representative.

All of the people we spoke with were happy at the home and the relatives we spoke with told us they had no concerns about the care people received. Relatives we spoke with said the manager and the staff team were approachable. One relative said the manager was "Down to earth" and all the relatives told us they would discuss any concerns they had with the manager.

We asked the manager if they had received any complaints about the service since our last inspection. They told us no complaints had been received.

Requires Improvement

Is the service well-led?

Our findings

We looked at the systems in place to enable the manager to monitor the quality and safety of the service. We saw that a range of audits were in place for this purpose. For example, there were medication, maintenance, equipment, health and safety and accident and incident audits. We found however that the audits were ineffective. They failed to identify the concerns we found during our inspection with regard to health, safety and cleanliness of the premises, the control of legionella, and the appraisal and training of staff members. Some of the audits were not accurate and most were generic which meant they lacked sufficient detail of the audit undertaken.

For example, the medication audits we looked at were generic. They failed to specify whose medication administration charts had been looked at, how many medicines had been audited and the findings. This meant the audit was meaningless.

Care plan audits were generic. They failed to specify whose care records had been checked for accuracy and completeness and whether any action was required. The manager confirmed they did not select any specific care records to look at during this audit. This meant that it was difficult to understand the purpose of the audit and how it identified and mitigated risks to people's health, safety and welfare.

The health and safety audit undertaken was a higher level audit that appeared to be more about the management of health and safety as opposed to an actual check on whether the premises was safe, suitable and clean. This audit was not always accurate. For instance it asked "Are all staff trained in manual handling". This had been answered 'Yes' but when we checked staff training records, we saw that three staff members had not completed this training.

An additional maintenance audit was undertaken each month but this audit was also not always accurate. For instance, the audit asked "Are all windows in good condition". This had been answered 'Yes' but on the day of our visit, we found that the window in one of the rooms did not close properly and the wooden window frame looked rotted.

Both the health and safety audit and the maintenance audit failed to identify that parts of the home required repair or were unclean. This meant they were ineffective. Issues with the management of the premises, its cleanliness and the ineffectiveness of the provider's environmental audits were identified at the last inspection despite this, we found that no effective action had been taken to address these concerns.

We saw that the manager completed an accident and incident audit based on people's falls but there appeared to be no recording system in place for other incidents such as safeguarding. Prior to our visit, we received information from the Local Authority to indicate that there had been a small number of safeguarding incidents raised and investigated by them. We found however that these incidents had not been recorded by the manager in any formal way and had not been included in the accident or incident audit. Deficiencies with this recording was discussed with the manager at the last inspection but had not been improved upon.

The manager told us that satisfaction surveys were available for people to collect and complete in the entrance area of the home. They told us that only a few surveys had been completed. This ad hoc approach to gaining people's feedback meant that the manager failed to gain a representative sample of people's views. This made it difficult for them to come to an informed view of the quality and safety of the service.

This evidence demonstrates that the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The domain of 'well-led' has been rated requires improvement again because of this. This will be the second time that this domain has been rated 'requires improvement'.

During our visit, we found the culture of the home to be open and transparent. The home was relaxed and homely. Staff were kind, considerate and compassionate in all their interactions with people who lived at the home and with each other. The manager and deputy manager were knowledgeable about people's care and it was clear that they cared that people received a good service. People and relatives were happy with the care provided and spoke highly of the service

The staff worked well as a team and felt supported and confident in the management of the home. Staff we spoke with told us the home was well-led and that they felt supported by the manager and deputy manager. One staff member said "(Name of manager) is a good manager, if you have any issues, they resolve them". Another staff member told us the manager was "Supportive".

The positive feedback from people who live at the home, their relatives and the staff team indicates that there were aspects of good leadership within the service that ensured people were happy with the service provided.

At the end of our visit, we gave feedback to the manager and deputy manager. Both the manager and deputy manager were receptive to our feedback and appeared to be committed to making the required improvements.

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 Parts of the premises required repair and were unclean. Fire safety provision and infection control standards were insufficient.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training, and appraisal in relation to their job role.