Neem Tree Care Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 3, 4 and 14 October 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day. The third day was also unannounced.

The last inspection took place on 29 May 2014 at which time the service was meeting the seven assessed standards.

Neem Tree Care Limited is part of Sunflower Health Care which has four homes in the North of England and Neem Tree Care in London. The home has three units over three floors and two of the floors provided support exclusively to people from an Asian background. Neem Tree Care Limited provides nursing care and support for up to 57 older people, including people with dementia. At the time of our inspection there were 49 people living at the service.

The registered manager was a nurse and had given in her notice prior to our inspection. After the inspection, the providers confirmed they had begun recruiting to the 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.

We found one breach of the Regulations because medicines were not always managed safely.

We saw during the inspection visit there was not always enough staff available, but after the visit, the provider had begun to recruit a full staff team and restructured the management of the service.

The service had safeguarding and whistle blowing policies. Staff had attended safeguarding training and knew how to report safeguarding concerns. Risks to people's safety and wellbeing had been assessed to keep people safe and staff knew how to record incidents and accidents. The provider followed safe recruitment procedures.

There were a number of regular maintenance and service checks carried out to ensure the environment was safe.

People were supported to have enough to eat and drink and were able to have food and drinks when they wanted to.

People had access to health care services and the service worked with other community based agencies such as a memory clinic.

People who used the service and their relatives told us staff were kind and their dignity and privacy was respected.

A complaints procedure was available and the provider responded appropriately.

The provider had systems to monitor the quality of service delivered and to ensure the needs of the people who used the service were being met. Information was analysed and used to improve service delivery.

All stakeholders indicated they could speak to the registered manager or providers who they felt listened to them.

We found a breach 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.

Medicines were not always administered in a safe way.

There was not always a sufficient number of staff. However, since the inspection visit, the provider had employed more care workers, created a task allocation sheet for care workers and restructured line management to improve service delivery.

There were procedures in place to safeguard people from the risk of abuse and staff knew how to respond if they suspected abuse.

Risk assessments minimised harm to people using the service.

Is the service effective?

Good

The service was effective.

Staff were supported through inductions, supervisions and appraisals.

The service worked within the principles of the Mental Capacity Act (2005) and understood the importance of obtaining consent.

People were supported with food and drink to meet their individual needs.

People's healthcare needs were met and we saw evidence of involvement with relevant healthcare professionals.

Is the service caring?

Good

The service was caring.

People who used the service had developed positive relationships with staff.

People's privacy and dignity were respected.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Good

The service was responsive.

Staff were aware of people's individual needs and the preferences of people living in the service.

There was a complaints procedure and people said they would speak with the registered manager or provider about concerns they had. The provider responded appropriately to concerns raised.

Is the service well-led?

Good

The service was well led.

The provider addressed concerns around management structure, clinical supervision and recruited more care workers.

People who used the service, relatives and staff said the registered manager and provider were approachable.

The service held staff and resident meetings and sought feedback through surveys.

The service had effective systems to monitor the quality of the service delivered to ensure the needs of the people who used the service were being met. Maintenance and service checks were carried out to ensure the environment was safe.

Neem Tree Care Limited

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.

The inspection took place on 3, 4 and 14 October 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day. The third day was also unannounced.

The inspection team on 3 October 2016 included an inspector, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience on this inspection had experience of caring for family members who use regulated services. The inspection on 4 and 14 October 2016 was carried out by an inspector only.

Prior to the inspection, the service completed a Provider Information Return (PIR). This form asked the provider to give some key information about the service, what the service did well and improvements they planned to make. Additionally, we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's Commissioning Team and Safeguarding Team for feedback.

During the inspection, we spoke with three people who used the service and four relatives. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We interviewed 11 staff including the registered manager, nurses, support workers, catering staff and domestic staff and we spoke with a visiting healthcare professional. After the inspection, we spoke to three more relatives and another healthcare professional.

We looked at the care plans for seven people who used the service. We also saw files for seven staff which included recruitment records, supervision and appraisals and we looked at training records.

We looked at medicines management for people who used the service. Additionally we looked at the environment, maintenance, servicing checks and audits.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. On the first day of inspection, we saw a prescribed medicine for one person had not been administered since the previous month. The GP said they were not aware of why the person was not being given the medicine daily. The provider told us the person had capacity and had refused the medicine but this had not been recorded properly. They advised the medicine had started two weeks before the inspection visit and they would have picked up the error during the monthly audit. Additionally for the same person, we saw a medicine had been signed for but was still in the blister pack indicating they had not received it.

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

Medicines administration was divided into residential administration managed by senior carers and nursing administration managed by nurses. During the inspection, we saw the medicine room and fridge temperatures were checked and recorded daily. Medicines were ordered, received, stored and disposed of appropriately. We looked at medicines administration records (MAR) and with the exception of one person as above, we saw evidence that people received their medicines at the right time and with no recorded gaps. We saw evidence of the manager's monthly medicines audit. When required (PRN) medicine protocols were in place and up to date. Protocols for the administration of covert medicines were seen and the care plan explained the crushing method. The GP and pharmacist signed their approval for the medicines to be administered covertly to people who did not have the capacity to consent. Topical medicines protocols and administration were also evident. We saw that nurses were trained and competent in the administration of medicines. The senior carers who administered medicines also had relevant training and competency testing was undertaken every six months.

People who used the service and their families told us it was safe. Relatives said, "It's always been safe. Never had any problems", "It's 100% safe. I'm so relaxed about it" and "I can confirm that my (relative) is supported and cared for safely at this home."

At the time of the inspection, there were a number of safeguarding concerns raised that were being investigated by the local authority. Subsequently the local authority and the Clinical Commissioning Group (CCG) visited the home and relevant parties were invited to two service strategy meetings. A number of recommendations were made from the local authority and the CCG's visit which were discussed at the first meeting. At the second meeting there was evidence that the provider had taken action to implement the recommendations and the local authority's investigation concluded that the provider had taken the appropriate action to address the individual safeguarding concerns including notifying the relevant agencies. General feedback from other stakeholders was positive.

During our inspection visit we observed there were not always enough staff present to meet people's needs, and staff we saw were very busy. For example on the ground floor at lunchtime, we observed the cook both serving meals and helping people who required assistance as the care worker was serving meals in people's

bedrooms. In another instance, a care worker required support from a colleague for a task and asked a member of the inspection team to help as there were no other staff available to help. We also saw there were not always staff available in the ground floor's television lounge to support people. We noted however, that on the ground floor due to an outbreak of diarrhoea and vomiting, more people were in their bedrooms than usual and therefore fewer staff in the communal rooms as they were assisting people in their bedrooms. A person using the service said it could "take a while" for people to be attended to as there were few staff and they were busy. Other comments included "I wish staff would spend more time talking with me, it gets lonely" and "Too many agency staff. They don't understand our needs, or care to". Relatives said, "Overall the service is very good and I for one am really pleased that my (relative) is in Neem Tree. The only drawback is staff shortages at times particularly recently", "I think they are short of staff" and "(Staffing) seems to be adequate for (relative's) needs. (Relative) has to be fed now (in their room) and it seems to be working fine. There are always carers walking in and out." The first and second floors appeared to have more staff and relatives present to support people using the service. On the three days we visited, the majority of people on the first and second floors were gathered in the first floor lounge taking part in religious activities with people from their religious community. The registered manager told us a number of permanent staff had left the service and there was a period of greater agency staff use.

However, after the inspection visit, the provider informed us the service had recruited a fully permanent staff team and had made changes to the line management so that each of the three floors in the home had its own unit manager to be responsible for the overall running of each floor. The provider showed us rotas for 24 October to 20 November 2016 which demonstrated unit managers had been appointed to each floor and a nurse was in the unit on the days the unit manager was not working. We saw three new care workers had been employed. On the first floor agency staff had been employed for ten out of 150 shifts, on the ground floor agency staff had been employed for one shift and no agency staff had been employed on the second floor. Additionally there was an allocation plan that identified what room numbers care workers were responsible for, who the nurse in charge was and who was responsible for supporting people in the lounge and in the dining room. Another schedule showed which manager was available during the day and who the on call person was out of hours. Collectively, this indicated that the provider had been proactive in taking steps to rectify the issues raised around staffing levels and management structure. More permanent staff meant a reduction in agency staff and provided greater consistency and having a unit manager identified who was accountable for each floor. The allocation lists showed what tasks staff were meant to undertake and helped to ensure staff were appropriately deployed across the service to meet people's needs effectively.

The service had safeguarding procedures and a whistle blowing procedure in place and staff knew which outside agencies to contact if they had concerns. Staff we spoke with had received training on safeguarding adults and demonstrated a good understanding of how to recognise signs of abuse, how to respond and who to report alerts to. This contributed to ensuring people were safe from the risk of abuse. Staff told us they would inform the senior carer or the manager and make sure the person was okay. They also said they would tell the local authority's safeguarding team or the Care Quality Commission if required.

We reviewed seven people's care plans and saw comprehensive and up to date risk assessments and management plans for people using the service." The risk management plans were specific to individual needs. These included complex nursing needs with care plans in place for people who had Parkinson's disease, who were diabetic, and who required percutaneous endoscopic gastrostomy (PEG) feeding. In response to the local authority and CCG recommendations, the service had reviewed their falls care plans and amended them accordingly so risks were assessed, identified and plans put in place to keep people safe. They had also appointed a "falls champion" who had additional training on falls management. Where people had pressure sores, we saw these were mostly acquired while in hospital or at home but the service

had recorded progress made in the healing process. The assessment and management plans for wound care were comprehensive with input from the tissue viability nurse. Care plans for pressure ulcer prevention were in place. Repositioning charts and skin care plans for people who could not mobilise were up to date. Information on observation charts, turning charts, fluid and diet charts was well recorded. The service used equipment such as pressure mattresses to provide relief. Bedrail assessments and risk management plans were in place. We saw evidence that equipment was checked regularly including a daily check of bedside rails, nurse call bells and mattresses.

The service had an up to date continuity plan that identified risks and actions. We saw up to date safety checks for fire equipment and weekly fire alarm tests. Staff undertook regular fire drills and people using the service had basic personal emergency evacuation plans. The service had an external agency complete a fire risk assessment in April 2016 and actioned the points raised.

The service followed safe recruitment procedures to ensure only suitable staff were employed at the service. The care workers' files had application forms, two references, Disclosure and Barring Service (DBS) checks, proof of identity and where required proof of permission to work. We saw that nurses' professional registrations were up to date.

Incidents and accidents were recorded appropriately in people's files and included details, action taken, what preventative action could be taken and any follow up action. The information was recorded electronically and included in a graph for quick reference. The registered manager looked at the incidents and accidents monthly to identify any common factors and then passed any relevant information on to the staff team. At the time of the inspection, the registered manager was undertaking a root cause analysis of the recent falls in the service.

On the first day of the inspection there was an outbreak of diarrhoea and vomiting on the ground floor, which affected nine residents. We observed that initially the service was slow to take action to prevent the outbreak spreading and there were not enough staff to meet people's needs. The GP considered the staff would benefit from further training on barrier nursing and infection control. However, by the end of the first day of our inspection, the second day of the outbreak, we saw appropriate measures had been put in place to prevent further spreading of the outbreak. The GP and the environmental health officer had visited the home and no visitors were allowed as part of the infection control measures implemented.

Overall, the environment was clean but we noted that tables and floors were not always thoroughly cleaned after meal times.

Good

Is the service effective?

Our findings

We asked people and their relatives if staff had the skills to provide appropriate care and support. People who used the service and their families told us permanent staff had the skills and knowledge to care for people in the home, however one relative felt there were too many agency staff who were less knowledgeable. Comments included, "The nurses are absolutely fantastic", "(Relative) has been very well looked after" and "The staff always look after my (relative). This was particularly apparent when they were not well recently." A healthcare professional told us some staff may benefit from a better understanding around dementia and mental health but also said staff contacted the appropriate agency if there was a mental health need.

We saw evidence care workers and nurses were supported to have the skills and knowledge they required to carry out their role. To address the issue of agency staff having access to people's electronic care plans, after the inspection, the service purchased tablets for each floor which offered access to all staff, including agency staff, to care plans. They also implemented new handover procedures where the nurse in charge briefed all staff, including agency staff, at the beginning of their shift and ensured staff had read the care plans.

Staff were supported through training, supervisions and appraisals. We saw from the files staff had an induction booklet when they first started and they told us their induction included shadowing more experienced members of staff, training and then a three month probationary period. The supervision matrix indicated supervision occurred once a quarter. A staff member told us that in supervision, "They will always tell you your good points and advise you with training and that helps a lot." We saw appraisals had comments from both the manager and the employee and both had signed them.

The training matrix indicated training for safeguarding adults, medicines, Mental Capacity Act training, infection control and moving and handling. Staff said they had ongoing training the provider considered mandatory and specific training such as dementia care and the management of challenging behaviour. We observed staff demonstrated a good understanding of people's needs which meant they could support people effectively.

Relatives told us they felt involved in making decisions and said staff kept them informed. One relative said, "They are very on the ball. They send an email straight away although I go there during the week."

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA. The registered manager understood their responsibilities under the MCA and made DoLS applications appropriately.

We looked at how capacity and consent to care was recorded. People who did not have capacity had best interest decisions recorded on their electronic file. We saw best interest decisions for administering covert medicines and for the use of bedrails, which indicated family involvement. Staff understood people had the right to make their own choices. One care worker said, "People have a routine so they get used to it but we always ask them first before we do something and we give them choices."

Relatives told us the food was "very good." People were supported to have sufficient to eat and drink. We saw tea and water being offered regularly. People were able to access food as and when they wanted to. There were two kitchens, one which catered for Asian meals and one for non-Asian meals. The kitchens had records of people's preferences and nutritional and dietary needs. Menus included a variety of choices and food was prepared freshly each day.

The service had two nutritionists on the staff team who told us staff had been trained regarding various food specification and fortified diets. The nutritionists focused on people who were at high risk of malnutrition and with a low malnutrition universal screening tool (MUST) score. We saw evidence of guidance for staff in the dietary care plans. Individual choices, preferences, religion and culture were considered. The plans were reviewed monthly and anyone losing more than 5kg in a month was referred to the community dietician. The dietician came two to three times a month to review people's supplements. MUST assessments were in place and there were well recorded fluid and diet charts.

People who used the service were supported to maintain good health and we saw records of health checks including weight and blood pressure. The GP visited every week and there was evidence of professional involvement from the dietician, speech and language team, the mental health home intervention team and the tissue viability nurse. A relative said, "Staff are good at making sure (relative) attends appointments with the memory clinic and changing (relative's) medication when they need to" and a healthcare professional told us, "They know about the patients. I have seen care plans and risk assessments as appropriate, and behavioural charts."

Good

Is the service caring?

Our findings

People who used the service told us staff were kind. Comments included "It's a lovely home. It's very caring", "Staff are kind and paint my nails" and "On the whole I'm happy here." Relatives said, "I've been very, very happy with the care. Very sensitive at the time when (relative) moved in with dementia."

The service had two floors which cared for people from Asian cultures. We observed they had a separate kitchen to cater for their meals and Asian staff were employed who understood their language and culture. Staff told us people felt happy and secure when they were supported by someone who understood their language and communicated well with them. We also saw the service provided information leaflets in Asian languages. Relatives said, "They are lovely carers. They are multi lingual. It's nice for (relative) to hear (their) own language", "I've always felt (relative's) at home. I've never felt they're in a nursing home" and "They're very caring people. (Relative) has dementia and they listen to them carefully. It's nice."

We observed staff interacting well with people who used the service. Staff appeared respectful and confident in their work providing the support and help people needed. Staff comments included, "At the end of the day, the priority is my residents" and "Here it's like a family. It's not like we come here to do jobs. Residents can feel at home. They miss their family so we are the ones who care about them."

People's privacy and dignity was respected. We saw staff knock on doors before entering people's rooms. When we asked care workers how they supported people with personal care, they told us, "You need to maintain their dignity and give them choices. It's in the care plan how they want to be cared. We always explain why we are there and what we are going to do." A relative told us, "Privacy is well respected."

People had the opportunity to make choices and were encouraged to be independent. We observed staff asking people if they wanted to attend activities and what drinks they would like. The registered manger told us when the service assessed someone, they assessed what the person could do for themselves and staff provided guidance and support in line with the risk assessment.

Good

Is the service responsive?

Our findings

When we asked if people and their relatives if they were involved in people's care, they told us, "(Relative) has a care plan we do yearly and we sit down together" and "The nurse sat with me and did the care plan. What (relative) likes, dislikes and needs."

We reviewed people's files and saw care plans reflected individual preferences and choices including cultural and religious needs. Pre-assessment forms included basic details, background, religion, culture, medical and mental health history and social situation. The care plans and risk assessments we viewed were up to date and comprehensive. Individual needs were stated and actions were specific to meet the needs identified. Care plans included dependency profiles, moving and handling, skin care, breathing and circulation, lifestyle, mental health and well-being, communication, a behavioural assessment tool, administration of medicines, future decisions plan and pressure ulcer prevention and management. The care plans indicated there was involvement of people who used the service and we saw comments and contributions made by relatives. End of life care plans were well documented and very comprehensive. The registered manager completed a monthly audit of care plans to ensure they were up to date and meeting people's needs.

Where management plans indicated the need for monitoring, we discussed with the providers the need to be more specific about how people were to be monitored. We saw evidence from charts that all people were monitored at night and we saw some people also had charts to monitor them during the day if they stayed in their bedrooms. However, there were a number of people's care plans which said monitor and it was not clear if this was occurring or not. In the examples we gave, the providers advised those people were in the lounge area during the day and monitored there but agreed to review how this was recorded.

Reviews were held after the first month, six monthly and then yearly. The electronic system had an alert to indicate when reviews were due. All the reviews we saw reflected people's current needs and included issues raised and actions taken. We could see appropriate referrals had been made, for example, to the falls clinic and the involvement of other professionals was sought as required, for example social workers. Most relatives said they were involved in care plans and received regular feedback from the staff. However, one relative said, "As for planning my (relative's) care, I feel this is one aspect which needs improvement as I can't recall any reviews relating to this." All staff were able to access the electronic system to update care plans. Nurses wrote up any clinical or medical notes from the GP and care workers wrote daily logs. Additionally there were daily charts which recorded people's nutritional and fluid intake, if they needed support with personal care, their position changed and monitoring.

The service had an activity co-ordinator five days a week for three hours a day to support people mainly on the ground floor. The activity co-ordinator told us they checked people's files to see what people liked and disliked and spoke to families if people were unable to say what they liked. Activities included ball games, board games, skittles, beauty sessions and life story books. We saw external people visiting the service included a trainer once a week to do exercises with people, a priest, an entertainment company and a magic show. The activity co-ordinator said outings were more challenging as it was difficult to access transport

that could accommodate the number of wheelchair users wishing to go out. Birthdays and festival days were celebrated in the service, and this was confirmed by relatives. We saw activities were recorded under the daily care notes on the system and included one to ones, old time songs and games. The record included the level of participation or if the person refused the activity. The co-ordinator also wrote a monthly newsletter to keep people who used the service and their relatives informed. We saw two emails from relatives with positive feedback about the newsletter. On the three days we visited, we saw most people on the first and second floors joined in activities run by people from the community, who were providing spiritual activities, including dancing and singing. After the inspection, the provider informed us that a second activity co-ordinator had been recruited for the first and second floors and was currently in post.

A health professional said there was "lots of stimulation" in the service for people. Relatives told us, "The main thing they do is activities which are very nicely done. I have seen people playing some activity with my (relative) in their room and others in the lounge doing activities. There are lots of activities upstairs and downstairs. It seems very vibrant" and "I think they are doing everything they can do. They have an activity lady and they do prayers. It would be nice if they had a bus to take people out."

There was an appropriate complaints procedure which acknowledged complaints within three days, investigated them, discussed the concerns with the family and then provided written feedback. A copy of the complaints procedure was in the reception area, which also gave information on how to contact the local authority. Relatives we spoke with said if they raised a complaint, it was dealt with quickly. This indicated that the service was responsive to people's complaints and addressed any areas of concern.

Good

Is the service well-led?

Our findings

At the time of the inspection, the registered manager had given in their notice. The deputy manager was identified as a clinical lead and allocated one supernumerary day per week to complete managerial duties. The nurses on duty were responsible for the deployment of staff and for the running of each floor on their shift. However, each unit lacked a manager with overall responsibility for service delivery. After the inspection, the providers informed us that they were recruiting to the post of registered manager and had begun interviewing for the post. The deputy manager was now in post in that capacity five days per week, they had appointed three unit managers to lead on each floor and had recruited care workers. In the interim, until a registered manager was recruited, the provider and an operations manager from another service were providing support. Additionally, a senior member of staff was always on call if required and we saw evidence from rotas that new permanent staff had been employed. The provider also told us they were establishing link / "champion" nurses in the areas of falls, dementia and tissue viability.

The service had effective systems to monitor the quality of service delivered and we saw audits that checked pressure sores, nutrition, falls, bedrails, medicines and care plan reviews so people's wellbeing could be monitored. There was evidence of analysis and action plans where appropriate. There were also audits for the environment that included maintenance, catering and infection control which looked at communal rooms, bedrooms and equipment. This helped the provider identify any areas for improvement. We saw findings were recorded and action was taken to address identified issues.

Management meetings were held monthly to two monthly. Agenda items for September 2016 included, falls, accidents, review of care plans, menus, the environment and an action plan for the safeguarding investigation to be completed. Staff meetings were also held one to two monthly. Safeguarding, recruitment and directions to nurses for a handover at the beginning of shift were discussed at the September meeting.

A relative told us, "They always listen to me. It's very nicely done." They said when their relative's medical condition was changing they asked for the carpet in their room to be replaced with a linoleum floor. "They did it quickly and that made a difference." Other relatives' comments included, "I normally speak to the nurse in charge on the floor if I have any concerns and they do take notice. The manager and the director are also very much approachable in such circumstances" and "There was a manager I could tell but I never had to complain." The registered manager had a good understanding of the needs of people who used the service and was visible in the service. Staff said the management are always open to complaints and available. Comments included, "I would go to the manager first but I haven't had to so far. I think she would listen if I did" and "She's the very, very best manager I ever had. She's easy to talk to and she understands if you have a problem and will work a way through it. "

Residents' meetings were being held annually but the service has recently decided to hold them six monthly. The minutes of the last meeting in July 2016 recorded there had been discussion around menus, activities, staffing and medicines administration. It also had an action plan. Relatives' meetings were held yearly and we saw at the June 2016 meeting, the discussion was mainly around menus. Previous meetings had discussed activities and we saw evidence the people using the service had the opportunity to voice their

opinion and contribute to how the service was run. The service undertook surveys in January 2016 for relatives and professionals. Twelve relatives responded and we saw an action plan was developed in response to concerns raised in the surveys. Surveys were not offered to staff, but the service has recently implemented an anonymous comments form for staff to feedback what they feel is going well and what could improve. Information on how to review the service on an independent website called carehome.co.uk was available in the reception area.

The service had good links with the local community and in addition to the health professionals previously noted, they had members of their religious communities regularly visiting the service.

The service kept up to date with current best practice and legislation through care journals, attending provider meetings, information sent from the provider and emails from the Clinical Commissioning Group and the Care Quality Commission.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment were provided in a safe way for service users because there was not always proper and safe management of medicines. Regulation 12 (2) (g)