

Indigo Care Services Limited

Paisley Lodge

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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an unannounced inspection carried out on 24 July and 2 August 2017. At the last inspection in May 2016 the provider was in breach of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12, Safe care and treatment which related to the safe moving and handling of people.

At this inspection we found that people were being appropriately and safely assisted to move because staff were trained to do so, and staff competency was refreshed with supervisions. Therefore the regulation was met. However, we found that clinical waste was not always secured safely, and doors that were required to be locked were not always secured. There were malodours observed in the corridors on both floors.

People's consent was not always recorded accurately and best interest's decisions were not recorded as being made in partnership with others.

People did not receive regular and stimulating activities, and activities provision had been limited by a vacancy for an activities co-ordinator that had not been filled. Although there was a quality monitoring system in place this was not always effective in identifying concerns or resulting in the required improvements. This was a breach in regulation. You can see what action we told the provider to take at the back of the full version of the report.

Paisley lodge is a care home located in the Armley area of Leeds. The home has 45 beds, providing care for older people and people living with dementia. The building was split into two floors, with dining rooms and communal areas on both floors. The building was wheelchair accessible, with security provided by keypad entry. There were 36 people living at the service at the time of the inspection.

The service had a registered manager who had been in post for two weeks. 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.

Medicine records were accurate and detailed, and pain charts were used to monitor the effectiveness of painkillers.

Staff were recruited safely, and there were enough staff to deliver care safely.

People were supported with their nutrition and hydration by competent and well trained staff. Food was highly regarded and people's food and fluid intake was assessed using nationally recognised monitoring tools.

People were cared for by compassionate and caring staff who created a warm, welcoming and friendly atmosphere. People spoke highly of staff who were looking after them.

Staff understood the importance of people's privacy and dignity, and told us how they ensured this was maintained.

People's care plans were detailed and person-centred. They were created in partnership with people and their loved ones. People's relatives told us the service contacted them frequently with any changes or updates to their relatives' wellbeing.

Complaints were recorded and responded to in a considerate, professional and timely way.

Staff told us they enjoyed working at the service and were supported with regular supervision. We also saw that staff meetings were held.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Doors that should have been locked were not always secured, clinical waste was not always secure and the service had malodours present in corridor areas.

Medicines were administered, stored and recorded appropriately. Appropriate risk assessments were in place.

Staff were knowledgeable about safeguarding vulnerable adults and were able to describe how they would recognise signs of abuse and report concerns appropriately.

There were enough staff to deliver care safely to people Staff were recruited in a safe way.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Consent to care and treatment was not always recorded accurately. Best interest's decisions were not always recorded as being made in consultation with others.

People were supported to maintain good health with appropriate access to healthcare and a nutritionally balanced choice of food, which people spoke positively about.

Staff were given appropriate induction and training which enabled them to deliver care safely.

Requires Improvement ●

Is the service caring?

The service was caring.

The service had a warm and friendly atmosphere. Staff knew people and what their likes and dislikes were.

Staff were kind, patient and respectful towards people they cared for. They were able to describe how they maintained people's dignity and privacy while delivering personal care.

Good ●

Is the service responsive?

The service was not always responsive.

People were not routinely being offered activities that were stimulating or interactive and there was no oversight of activities provided at the service.

Care plans were person centred and reflected how people wanted to be treated.

People knew how to complain and issues raised were responded to appropriately.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

The service had a new manager in post who had started to implement changes and had ideas for improving the service.

There were systems in place to monitor the quality and effectiveness of the service provided. However, we found they were not always effective in bringing about improvements.

Feedback from people was sought and acted upon.

Requires Improvement ●

Paisley Lodge

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 inspection took place on 24 July and 2 August 2017, and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, the registered manager was asked to complete a Provider Information Return (PIR). This form asks providers to give some key information about the service, what the service does well and what improvements they plan to make. The provider returned this to us in a timely way. We reviewed this information as well as all other information we held about the service before the inspection. We also asked partner organisations such as Healthwatch and the service commissioners for any information they held prior to our inspection.

During the inspection we spoke to six staff (including the registered manager, head chef, activities coordinator and senior carers), four people who used the service, five relatives and three visiting health professionals. We reviewed eight care records, and spent time looking at other documents and records relating to people's care and the management of the service, such as medication administration records and staff duty rosters. We looked around the premises, and observed lunch.

Is the service safe?

Our findings

At our last inspection we found that the service was in breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because staff were observed not following safe moving and handling instructions which were available in people's care plans. At this inspection we saw people being moved in a safe way. All staff had completed moving and handling training. At the time of the inspection, there was only one person who required use of a hoist and the registered manager was monitoring its use. When we reviewed this person's care plan we found that risks had been assessed appropriately and the care plan was regularly reviewed. One member of staff said, "Yes, we've had a competency check on the hoist."

At this inspection we found that the sluice room and the medicine rooms were not properly locked. When we raised this with staff they immediately closed and locked both doors.

We also found that the key to the sluice rooms on both floors were either in the lock or on a chain next to the door. This meant that people could access the sluice area which was not safe for vulnerable adults.

We saw that clinical waste was not always stored safely. Clinical waste was kept in two lockable bins outside the home next to the other general waste bins and staff smoking area. This area was not fenced off and the public could access the waste storage area. On the first day of the inspection we found that while one bin was empty and locked, the second bin was overflowing with clinical waste and not locked. When we raised this with the manager they immediately moved waste into the empty bin and informed us that a collection had been arranged for that day. When we returned on 2 August 2017 we found that the bin was not full however, it was still open. When we raised this with the manager they informed us the lock had broken and we saw maintenance staff arriving to fix this.

People who used the service told us the carpets in communal corridors had unpleasant odours and we also experienced this. We saw a relative had made a formal complaint to the provider about the smell. We were told by the registered manager that a programme of deep cleaning had begun and that future plans were in place to replace the carpets with appropriate flooring, although we were not given a timescale for this.

This was a breach of Regulation 15: Premises and Equipment 1 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

We saw there were sufficient staff to deliver care safely to people. The registered manager used a dependency tool to calculate the number of staff needed on a shift and this changed along with people's needs. We observed that staff were visible during the inspection and had time to sit and talk to people. Staff we spoke with gave mixed feedback about the staffing levels, but were on the whole positive. One member of staff told us, "We do have enough staff. The only issue is nights, as two of the seniors on nights are brand new." Another member of staff said, "There are four staff here and we aren't full so it's not too bad. Two people are leaving us to go for nursing care. We are alright." One relative commented that, "Staff are always

busy, but they spend time with and remember who people are. They are chatty and sit with people."

There were appropriate recruitment processes in place to ensure staff were recruited safely and that they were suitable to work with vulnerable adults. We reviewed six staff files including two new recruits and found that appropriate background and identity checks had been carried out, with copies of photographic ID, professional references, interview questions and Disclosure and Barring Service (DBS) checks present. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use care and support services.

The service carried out health and safety checks. These included a five year electrical safety certificate, gas safety certificates, legionella bacteria testing, fire safety equipment and water temperature testing. The registered manager kept a file of all certificates, work requested by maintenance staff and work that had been carried out. The service was rated five on its food hygiene certificate, where zero is the lowest score and five is the highest. Everyone living at the service had personal emergency evacuation plans in place, and the service had carried out a thorough fire safety risk assessment, which showed that fire safety equipment was tested and evacuation drills had been practiced. Window restrictors were in place to prevent vulnerable adults from falling from height.

The home was pleasantly decorated. People's doors to their rooms were brightly coloured and designed to look like the front doors of houses. The occupant's name was on each door alongside a memory box which had pictures that represented people's personalities or likes, for example religious symbols or their favourite singers. Communal bathrooms, dining rooms and toilets were clearly signposted. Each floor had a communal lobby with a seating area and at the end of each corridor was a bench so people could rest when moving around the home.

The service had a garden. However, people were not able to access the garden unaccompanied because of repeated incidents of vandalism to the fence which left the home without a secure boundary. We were assured that people were kept safe because people who wanted to go into the garden were always accompanied by staff, and people told us they were able to go into the garden when they wanted to. The manager told us that they had liaised with the local school and constabulary with a view to educating local children about the impact vandalism was having on people living at the service. They told us, "We want to spend time with kids so they understand who lives here. I've spoken to the head teacher and children will come into the home and meet residents."

We looked at the management of medicines. Staff undertook medication training, and staff competency was routinely tested through spot checks conducted by the registered manager. We saw 94% of staff had completed medicines training. The service had three levels of audit for medicines, a weekly check of MAR (Medicine Administration Record) sheets, a monthly registered manager's audit and yearly audit conducted by Lloyds' pharmacy. The registered manager's audit had been recently introduced, and included action plans to make sure staff were continually improving the recording of medicines, and when we looked at medication records we found all medicines were signed as administered. Where there was a gap in signatures this were clearly explained by staff.

MAR sheets had photographs of each person and detailed medicine and allergy information. Where people had refused medication this was clearly recorded with reasons why and actions taken. Where medicines were directed to be given 'as required', this was clearly recorded, for example the time of administration of paracetamol was recorded. Where topical creams were prescribed these were recorded on topical medicine administration record (TMAR) charts which had information on how often a cream was to be applied and to which part of the person's body using body charts and written descriptions.

Although we found that the door to the medicines room was not always secure, medicines themselves were stored safely in locked medicines trolleys, fridges and cupboards. Fridge temperatures were recorded and stock checks were accurate. On medication rounds we observed staff wearing red tabards to signify to others not to disturb the member of staff delivering medicines. Staff knew how people liked their medicines, and we saw staff ring a person's GP when they observed that the person had refused their medication.

Where people had medicines prescribed for pain, staff used a visual pain chart to record how much pain people were in, and this was observed over time so that staff knew whether the medication was effective, for example we saw a history of pain chart used where one person's pain started being recorded at a high level and then had decreased over a period of days when they had been prescribed painkilling medications and administered 'as required'.

Staff understood their safeguarding responsibilities and how to raise a safeguarding alert. Staff had received training in safeguarding. One staff member said that safeguarding meant, "Any harm, for example if you see the family or staff doing anything wrong." We found that safeguarding referrals to the local authority were made appropriately and in a timely way. The Care Quality Commission (CQC) was notified as required.

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 found consent was not always recorded accurately. People signed a form to consent to treatment, which was placed in their care plans and, where people did not have capacity, two signatures were required. We found that in all eight care plans we looked at, the consent form was not filled in fully. In one care plan we saw that a person had been recorded as lacking capacity, however, the only signature present was their own. This meant that the person had consented to treatment that they were unable to understand. In other care plans, we found that this had been completed by senior staff with no evidence of relative or managerial approval as required by the document. We also found that the provider's most recent quality assurance monitoring report had identified care plans where consent was not signed or was absent. We asked staff how they gained consent, and they told us that if people did not have capacity they would contact their families. One senior carer we spoke with said, "We do speak to families and doctors, mainly families, and also the manager. We do them [best interest decisions] together" however the records did not show this. Staff told us they understood the principles of the MCA, and that they received MCA training. One senior carer we spoke with said, "Some people don't understand they have an illness, sometimes you have to make a decision for them, for example they might not know they need medication. We always just explain what we are doing."

People's nutrition and hydration needs were met by staff. We observed lunch at the service. The dining room was pleasant with easy to clean flooring. The dining room was odour free and there were food themed decorations and posters on the walls. Pictorial menus were provided to help people living with dementia to choose foods they liked. Where people had sensory impairments, brightly coloured plates and cutlery were provided. Staff wore aprons and washed people's hands after obtaining their consent. All meals provided were nutritionally assessed to ensure people were supported to eat healthily. People had a choice of hot or cold options and refreshments were offered throughout. We saw that one person did not want either of the options, but wanted cheese on toast instead. We saw that this person received this promptly, and when another person sitting at the same table also wanted this option they were given it straight away.

People and their relatives spoke positively about the food at the service. We spoke to one person eating in

the lounge while watching TV who told us, "The food is very nice thank you. Delicious. I've got carrots, mashed potatoes and some mince." A relative told us, "The food always looks good quality. They give mum what she likes to eat and snacks throughout the day. She was awful at eating and drinking when she was living with us, but they [staff] encourage her here. She has put on a stone." Another person we spoke with said, "The food's okay, we are well fed and looked after."

The head chef and kitchen staff were knowledgeable about people's dietary requirements, such as pureed, fork mashed and diabetic food. Staff corroborated this. We saw people were regularly weighed, and the serviced used a Malnutrition Universal Screening Tool (MUST) to establish nutritional risk for people. Where high risk was identified we saw staff liaised with people's GP's to address the concerns and formulate care plans, so that where necessary people were prescribed high calorie drinks.

People were supported to access healthcare appropriately. People's care records held logs where all healthcare professional visits were recorded. Relatives told us staff were proactive in calling health professionals regarding any concerns they had about people's health. One relative we spoke to told us, "They get doctors in [for mum] to sort her out." We spoke with two visiting general practitioners to ask their opinions of the service and whether they felt people were getting appropriate access to healthcare. Both spoke positively about the service. One told us, "It's fine, honestly, I look after lots of homes. They [staff] are caring and follow my instructions without issue. Compared to other services this is good." Another health care professional told us, "They are quite proactive, so I have no major concerns. They are perhaps even over cautious. I have had no bad experiences and no medicines concerns; they are good at getting things in order. We have a good rapport."

We looked at how staff were trained to meet the needs of people who used the service. We looked at the training matrix which recorded what training staff had completed. This showed that 96% of all staff had completed training that was considered essential by the provider. Examples included safeguarding vulnerable adults and medications administration training. The training matrix used a red, amber and green coding system to identify where certain modules were within date, coming up for renewal or overdue. The manager was able to view individual staff training records and identify what training staff needed to receive.

We saw staff were given an induction to the service. Staff we spoke with told us this was effective in preparing them for their roles. One staff member told us, "The induction was good, around four weeks, but I've learned a lot more since." Staff were able to request and access additional training where they felt it would improve their skills. One to one meetings were held with staff regularly and we saw training was a topic of discussion. One member of staff told us, "I approached the manager about doing my NVQ (National Vocational Qualification) and I've already done further continence training. There is good support."

Is the service caring?

Our findings

People we spoke with as part of the inspection process were complimentary about the care and service they received. The home had a relaxed and homely atmosphere. One person told us, "She [staff member] is my best friend. I don't know what I'd do without her." Another person told us, "We have a laugh. They're a right lot here!" Someone else we spoke to told us, "No excuses, it's a really nice place to be in. We have a good rapport between us and get on well." We spoke to a visiting occupational therapist who had held exercise sessions for people at the home in the past. They told us, "Staff here join in and encourage others. At other homes they just leave you to it. They are friendly staff."

People were supported to live independently. We observed people walking around the home and choosing how they wanted to spend their time. When people wanted to go outside, they were supported to do so. People who wanted to eat in communal areas, the lounge or their own rooms were supported and this was also documented in their care plans. One relative told us, "I can give mum money to go to the shops and we get the receipts. It's good to promote independence." On the day of our inspection we saw people being taken to the shops to buy newspapers, and everyone was asked if they wanted to join in.

People had access to advocacy. We saw literature on the walls on how to access advocates, and the registered manager told us that they had contacted an advocacy service for people from the black and minority ethnic community for a person using the service. The registered manager also told us that they planned to hold a Caribbean night at the service to help this person feel more included and better understood by other people.

People were supported to maintain links with those who were important to them. One relative told us, "We can come [visit] any time; they [staff] aren't on show and everything's always spot on." Another relative told us, "We take mum out whenever and she's been to the garden centre. We aren't frightened to leave her and we don't keep rushing back to double check."

Staff told us how they maintained people's dignity and privacy. They told us that there were some people who could become confused and get undressed in communal areas, so staff asked for a screen which they told us they used to assist people to the nearest quiet space where they could help them dress discreetly. One staff member said, "We never do anything without consent unless it's a major issue. If people did refuse our help we would spend the time to talk them round. We also don't like people having odd socks and shoes so we make sure they aren't." Another member of staff told us, "We always respect it [people's dignity]. I always knock on doors, make sure doors are shut before delivering personal care, and don't embarrass people. How I would expect to be treated myself." One relative told us, "They [staff] are always respectful even when [Name] is in bed. [Name] can sometimes take their clothes off but they [staff] are very respectful and go above and beyond."

We saw the service had received cards of thanks and other letters complimenting the staff. One such card read, 'Thanks for making my dad's time with you very special. You are all truly amazing and do an amazing job.'

Is the service responsive?

Our findings

We found that although there was a programme of activities and a dedicated activities co-ordinator, they were not sufficiently supported to deliver a regular and meaningful programme of activities to people. The provider conducted quality assurance spot checks, and in the spot check for June 2017 we observed they had concluded that, 'Residents were not being stimulated or included in the activities in the home.' The activities co-ordinator only worked three days a week in that role. This meant that only 20 working hours of dedicated activities were delivered per week. As this person was also a trained carer, they often worked their activities hours within their role as carer which could take them away from the activities role when people needed help. At the last inspection, we found that there were 40 working hours of activities provided. The provider had a vacancy advertised for an additional activities co-ordinator, however the registered manager had been unable to fill this role at the time of the inspection and staff told us that this had been the case for, "Two to three months."

Although we were told staff helped to deliver activities, staff had not received any training in delivering activities, and there was no oversight of the activities plan or audit of activities logs. There was a social, cultural and religious care plan in which people's hobbies and cultural interests were recorded, however where the care plan required a log of daily activities we found that in all care plans this was not done daily and when entries were made they were lacking in detail. For example, in one person's activities log for 2 July 2017 we saw written, 'Relaxing in reception', and in the next entry on 7 July 2017 we saw, 'Relaxing in reception'. The service had a weekly plan of activities, however we were told by staff that this was subject to change and was rarely reflective of the activities conducted.

We did see however that all staff made efforts to encourage people to engage socially. For example, we saw a member of staff entertaining people with singing and conversation, which people responded well to. We also saw a member of staff taking people to the shops to buy newspapers, and people told us they were supported to go outside. Where the service did have planned events, these were well attended and liked by people. We saw pictures of people engaged in activities ranging from Christmas themed events (including a Santa's grotto) to a 1950's day with candy floss, to a foot spa session. Staff told us that activities used to be more formalised with regular entertainers and a pat dog. However, over time these had become infrequent or no longer happened. For example, we were told that, "There aren't really any community links. Although the local vicar comes now and again; he will just ring up and come."

We reviewed care plans and records. We found that people were appropriately assessed before entering the service to ensure the support was able to meet their needs. Care plans covered a range of areas including medication, mobility, communication, going to bed, nutrition and hydration and hobbies and interests. Care plans generally included people's life histories. However, these were often inconsistently recorded. For example, one person's care plan had five pages of detailed life history; and in another person's care plan we found there was no life history. One staff member told us, "Lots of it [information] is from families and word of mouth." Although care plans contained formal reviews with people and people's relatives told us the service was good at communicating with them, this was often not documented in the care plans.

Individual care plans themselves were person centred, with individualised instructions to staff so that people received care in a way that was tailored to their needs and wishes. For example, in one person's eating and drinking care plan we saw staff had written, '[Name] prefers to eat in the lounge, because he does not like the atmosphere in the dining room as it can be too loud.' We saw that this person was receiving their midday meal in the lounge as specified by the care plan. In another person's communication care plan it was written that, 'Due to [Name's] poor hearing, staff need to speak clearly and make eye contact' and in their food and nutrition care plan it said 'Staff sit and answer [Name's] questions, and encourage her by saying things like 'ooh try a bit of this', or 'are you hungry?' as [Name] can become confused by food.' In another person's 'going to bed' care plan the instructions stated that, '[Name] would like night staff to offer him a hot cup of tea & supper with his night medications.'

People's relatives told us that the service was regularly in touch with them to update them on any changes to people's wellbeing or any incidents that had taken place. We also found that care plans were reviewed with people's relatives on a regular basis. One relative told us, "They [staff] include us in whatever they do."

We found that complaints were recorded adequately and in sufficient detail. Complaints were responded to promptly and professionally. There were three complaints in 2017. All of these complaints started as verbal complaints, which were recorded on the verbal complaints form and were followed up by a formal investigation. We saw evidence that, where necessary, safeguarding processes and investigations were triggered. There was a complaints policy which clearly stated how complaints were to be recorded and what the timeframes for responses were. One relative told us, "Yes, there is a complaints form and they [staff] told us to let them know if there were any issues."

Is the service well-led?

Our findings

There was a regular programme of audits and quality assurance processes throughout the service to ensure the service was able to assess the safety and quality of the service. We found that the provider also conducted regular and detailed quality assurance visits, highlighting areas for improvement and actions to be taken immediately. However, we also found that where the quality assurance processes highlighted concerns, these had not always been addressed or any actions taken to mitigate these. In one quality assurance report conducted by the provider, they concluded that, 'Residents were not being stimulated or included in the activities in the home', and that when they looked at consent to care and treatment documentation that there were care plans where this was missing or not filled in correctly. The audits had also failed to identify issues affecting safety of the premises.

Therefore we found that the service was in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulations 2014).

We found that the registered manager was introducing more thorough audits, for example they had begun to audit all care plans and we saw some completed examples where issues were identified and actions required. The registered manager told us they had plans to address concerns identified. This demonstrated a commitment to continuous improvement.

At this inspection we found there was a registered manager in post who was supported by senior carers, managers in other homes run by the provider and the area manager. At the time of the inspection, the registered manager had only been in post for two weeks. One staff member told us "I've known [registered manager name] a while, I can't fault her, she is professional and knows what she is talking about." Another member of staff said, "We were worried, but the manager said give me a chance. She's got ideas and knows her job."

We asked staff about the working culture at the home. Staff told us they enjoyed working at the service. One member of staff said, "We've got good morale, you won't get another team like it and we cover each other. We love residents so much." Another member of staff said, "It's a vocation. Not about clocking off. We think about residents, we ring each other. My Mam could come here." Staff told us they would recommend the service as a place to live and work.

The registered manager had recently introduced daily 'flash' meetings with the senior carers. We saw that these discussed occupancy, deaths, infections, safeguarding issues, complaints and sickness. They gave staff the opportunity to discuss any issues or concerns they had in their teams. Staff told us they thought the flash meetings were a positive idea. One staff member told us, "Flash meetings are good. We can bring things up if there is a problem. We used to have senior meetings, but they weren't regular." The service did have staff meetings. One member of staff told us, "At this most recent staff meeting the manager told us what she wanted to do. Previously, we just fired questions for an hour. The manager wants to make things right."

The registered manager had oversight of all complaints, accidents and incidents within the home. We found

that CQC were given appropriate notification of all incidents as required by regulation.

We found that although the service had held resident and relatives meetings, these had not taken place on a regular basis. Since November 2015, there had only been two residents and relatives meetings, the latest being July 2017. The registered manager acknowledged this, and showed us that they had planned in their calendar to hold regular meetings as a matter of priority. They had already held their first residents' committee meeting. The registered manager told us, "We never had a residents' committee. We set one up, and they told us they wanted newspapers, so now three or four residents will go out with staff to get papers for everyone." The service also sent out an annual survey, and the responses from people were very positive, with the service scoring highly in all areas including care quality and food.

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 15 HSCA RA Regulations 2014 Premises and equipment The environment and premises were not always secure to prevent vulnerable adults from harm.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance processes were not always followed up with actions taken to address concerns.