Edgehill Care Home Limited

Edgehill Care Home

Inspection report

Buttermere
Liden
Swindon
Wiltshire
SN3 6LF

Tel: 01793641189
Website: www.agincare-homes.com

Date of inspection visit:
31 January 2018
01 February 2018

Date of publication:
07 March 2018

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Edgehill is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Edgehill provides accommodation with personal care for up to 60 people. At the time of our inspection 56 people were living in the home.

At the last inspection in November 2015, the service was rated Good. We carried out a comprehensive inspection on 31 January and 1 February 2018. At this inspection we found the service had deteriorated to Requires Improvement.

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.

People's medicines were not safely managed. Staff did not always administer medicines safely, in accordance with the provider's policy or national best practice guidance.

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was monitored. Staff received supervision and training to ensure they could meet people's needs.

Staff demonstrated a good understanding of safeguarding and whistleblowing and knew how to report concerns.

Risk assessments and risk management plans were in place. We found improvements were needed to ensure all appropriate actions were taken to keep people safe.

Incidents and accidents were recorded and the records showed that actions were taken to minimise the risk of recurrences.

People were supported with food and fluids and provided with choices at mealtimes. Where people were assessed as at risk of malnutrition, they were monitored and actions taken in consultation with external health professionals.

Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

Activities were provided. Recruitment was taking place for dedicated activity staff posts.

Systems were in place for monitoring quality and safety and actions were taken where areas for

improvement and shortfalls had been identified. The audits had not identified the shortfalls we found.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of this 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 deteriorated to requires improvement.

Medicines were not safely managed. Medicines were not given in accordance with the provider's policy or current best practice guidance.

Risk assessments were completed and risk management plans were in place.

Accidents and incidents were recorded, reported and analysed. Actions were taken to minimise the risk of recurrence.

Sufficient staff were deployed during the time of the visit. Additional staff were being recruited to take on dedicated activity coordinator roles and responsibilities.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Requires Improvement

The service deteriorated to requires improvement.

Quality assurance systems did not always identify shortfalls so risks to people were not mitigated.

People, relatives and staff spoke positively about the leadership and management of the home. They were given opportunities to provide feedback and actions were taken to make improvements.

The registered manager had developed links with the local community and worked well with external professionals.

A culture of continuous learning and development was actively encouraged.

The registered manager was aware of their responsibilities with regard to notifications required by CQC.

Edgehill Care 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.

We undertook a comprehensive inspection of Edgehill Care Home on 31 January and 1 February 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection took place on 31 January 2018 and 1 February 2018 and was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector. An expert by experience supported the inspection on 31 January 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider for key information about the service, what the service does well and the improvements they plan to make. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 18 people who lived at the home and seven visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the operations manager, the registered manager, the deputy manager and 12 staff that included care staff, housekeeping and catering staff. We also spoke with a visiting health professional. We observed medicines being given to people and how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at four people's care records in detail and checked other care and monitoring records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance

audits and action plans, records of meetings with staff and people who used the service, complaints records and other records relating to the monitoring and management of the care home.

Requires Improvement

Is the service safe?

Our findings

People did not receive their medicines safely. We observed people being given their medicines. The care staff did not always follow good infection control practices. They handled medicines, supported people to take their medicines and did not wash hands between administrations. Staff signed the medicine administration record (MAR) sheets to confirm administration before the medicines had actually been given to people. They told us this was usual practice within the home.

One person had not received two of their medicines, one for a period of nine days and the other for a period of 12 days. This meant the person's symptoms would no longer be controlled which could potentially have an adverse impact on their quality of life. The person's MAR instructions were hand-written and signed by one member of staff. This was not in accordance with the provider's policy that stated two staff must sign on occasions where handwritten transcriptions of prescribing instructions were made. The care staff told us the medicines were out of stock and they had experienced difficulties in obtaining new supplies. However, they had not reported this and the registered manger was not aware until we brought this significant shortfall to their attention. We were told the person's medicines had been received and given to the person before the end of our visit.

There were photographs at the front of most MAR sheets which meant people could be easily identified. However, the person who had not received their medicines as noted above, did not have a photograph in place.

There was a system for recording the receipt and disposal of medicines. However, we noted medicines for one person had not been signed for when they had been received into the home. We also noted where medicines were not received in dossett containers, amounts left over from the previous month were not always recorded. This meant staff did not know what medicines were in the home at any one time.

Homely remedies, medicines that can be bought without a prescription or 'over the counter' were in use in the home. There was no record that people's GP's had agreed to the use of these medicines for their patients. This was not in accordance with the provider's policy that stated, 'Written authorisation is given by the GP for the use of household remedies.' In addition, accurate stock level records were not maintained. This also meant staff did not know when these medicines had been given to people, or the amounts of medicines that were in the home at any one time.

Where people were prescribed topical creams, to be applied onto people's skin, records of administration were not always completed. The GP had prescribed creams to be given as required. For most creams there were no instructions for the frequency of application required or the specific part of the person's body the creams were to be applied to. This meant people may have not have received treatments when they were required. The care staff showed us records they were planning to introduce that included body charts that would be completed to show where and how often creams were to be applied, however these records had not been introduced.

One person who lacked the mental capacity to understand the effects on their health by not taking their medicines received them covertly. This meant they did not know they were being given and their medicines were disguised in food or drink. There was no record the pharmacist had been consulted and involved in the decision making or had given guidance about the suitability of types of food and drinks used to disguise the medicine. The provider's policy confirmed the expected role of the pharmacist when covert medicines were being considered. Before it was agreed to give medicines this way, there had been a discussion with the person's social worker, independent mental capacity advocate and GP. It was agreed that giving the medicine covertly was in the person's best interests. However, there was no record of regular comprehensive reviews since the decision had been made, to confirm other less restrictive options had been considered. The provider's policy for covert medication had not been followed.

The above amounted to a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the end of our visit, the registered manager had produced an action plan to confirm how most of the shortfalls noted above, were being addressed. They followed this up with a senior staff meeting to discuss the shortfalls, and sent us the notes from the meeting.

Staff spoke to people respectfully and gave people time to take their medicines. Staff clearly knew how people liked to take their medicines and people were not rushed. Staff explained the medicines they were giving to people. For example, we heard, "This is the one you chew" and, "Shall I tip them out onto your hand."

Where people had medicines prescribed 'as required' (PRN), protocols were in place. These included information for staff such as, 'Takes Paracetamol for headaches.' Where assessed as able to do so safely, arrangements were in place for people to self-administer their medicines.

Medicines were safely stored. Arrangements were in place for medicines that required cool storage and those that required additional security.

Staff were not always recruited in line with the provider's recruitment policy. We checked three staff recruitment files. Two files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. One staff record did not have references in their file. Reference requests had been made, but had not been received. The registered manager told us they would follow up this oversight as a matter of urgency and obtain the required references. We looked at an audit completed in January 2018 when five recruitment files had been checked and references were in place for the files checked at that time.

People and relatives all told us they felt safe in the home. Comments included, "It is very very good here and I feel safe," "Yes I feel safe most of the time here," "Yes, he is safe. I wouldn't have brought him here otherwise" and, "Always safe, been here five years, day and night, all good."

Most of the people we spoke with told us staffing was sufficient and on most occasions staff responded to calls for help and support in a timely manner. One relative commented, "You have to walk some distance sometimes, especially at weekends to find staff." A relative told us, "There are probably enough care staff now, but the residents are bored quite a lot of the time because there aren't the staff to provide enough activities." We spoke with staff and the comments from one member of staff reflected the feedback we received from others. They told us, "The biggest challenge is staffing. We don't have activity staff although

we know the managers are interviewing. That makes it hard for us, as we try to entertain people as well as provide care." We spoke with the management team who acknowledged that staffing difficulties had been experienced, exacerbated by the recent outbreak of sickness that had affected staff and people living in the home. They told us staffing had now improved, they still had activity posts to fill, but there was a consistency in the numbers of care staff on duty each day.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. Staff had also received training and understood how they made sure people were not discriminated against and treated equally and without prejudice The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. A member of staff commented, "I would report any concerns and 100 percent confident they (management team) would follow up as needed."

Risk assessments were in place that identified specific risks to each person. These included risks associated with moving and handling, nutrition, falls, distressed or challenging behaviour and skin condition. Risk management plans provided written guidance for staff on how to minimise or prevent the risk of harm. Risks were regularly reviewed and updated when things changed so that staff had access to up to date information about how to safely meet people's needs. One person used a wheelchair and had requested not to have footplates attached so they could move themselves independently and 'self-propel' around the home, using their feet to move the wheelchair. A senior member of staff told us they agreed to this after consulting an external health professional to seek their views.

Accidents and incidents were recorded and audits were completed each month to identify any themes or trends and actions were taken to minimise risks of injury and recurrence. For example one person had fallen and it was recorded they were, 'Unaware of personal risk, she is able to walk short distances with a frame but required close supervision' and for another person they were referred to a specialist nurse for a review of their medicines.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. Personal emergency evacuation plans for each person were in place. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required.

Most areas of the environment were clean. We spoke with a member of the housekeeping team who described their role and responsibilities. They told us about the cleaning routines and how the housekeeping team were allocated to different areas within the home. We observed staff using gloves and aprons when needed which showed good infection control practices. Staff were able to describe the main principles of infection control. However we did note some of the metal frames of commode chairs in people's rooms were dirty and stained. We brought this to the attention of the registered manager at the time. One person also commented, "The commode needs emptying more often. I do worry sometimes and you really have to grumble to get it emptied."

Good

Is the service effective?

Our findings

People received effective care from staff who had received training and support to carry out their roles. Staff told us they felt well supported by each other and the management team. One member of staff commented, "We have lots of training and just ask a manager if we're not sure."

When new staff started in post they completed an induction programme and then shadowed colleagues allocated as, 'buddies' to gain practical experience. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support.

Staff spoke positively about supervision and the support they received with comments including, "Not sure how often it (supervision) is but we do have them and I feel so well supported here" and, "I feel listened to."

The registered manager kept a training record that showed staff were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. The provider employed an Admiral Nurse, a specialist dementia nurse. They provided additional guidance and support for caring for people living with dementia and for supporting people with distressed or challenging behaviours.

The records showed, at a glance, when staff had completed and when their next training was due. A member of staff told us, "The training is really good and covers whatever we need to know about. If we suggest training it's taken up too." Where staff needed training to meet the specific needs of people living in the home, this was provided. For example, one person with specific health care needs was visited by a specialist nurse who provided advice and guidance about the person's condition and about the significant potential side effects of the medicines they were prescribed.

People had access and were referred to external health professionals. The registered manager and the deputy manager told us about the specialist nurses who provided support to the home. and the community nurse visited most days. They worked with the Community Matron to help proactively monitor peoples' health, aiming to avoid unnecessary hospital admissions. For nominated people, the staff team took, recorded and reported on blood pressure, temperature and oxygen levels. The local NHS urgent care centre checked the results and follow up actions were taken if needed.

We spoke with a visiting health professional who spoke positively about the care people received. They told us staff were observant, reported when people's conditions changed, carried out instructions and followed advice and guidance. Local health professionals were welcomed and often used the home as a venue for their team meetings.

We observed meal service to people in the dining rooms and to people who stayed in their rooms. Most people chose their meals in advance. The meal we observed being served to people looked nutritious and appetising, and where people needed support this was provided. For example, we heard one person

being asked, "Are you ready for your breakfast now? Would you like me to help you?" and another, "Shall I cut it in half for you. Just look at this lovely roast dinner." Comments about the food were mixed and included, "He is eating really well here" "The food is marvellous" "It' ok most of the time" and, "I'm not really happy with the food but I am a fussy eater". One person told us they had made their likes and dislikes known, but they were sometimes served food they did not like. They told us this was changed if they requested it but on some occasions, they told us they just left the parts of the meal they didn't like or want.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought in a timely manner. People were referred to the GP and prescribed supplements if needed. Some people had been assessed as needing their food and fluid intake monitored. We checked monitoring charts at random and found three that had not been fully completed. We brought this to the attention of the registered manager who told us they would take action to address the shortfall.

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.

Consent to care and treatment was generally sought in line with legislation and guidance. Throughout our visit we saw and heard staff asking people for consent with questions such as "Are you ready to?" and, "Shall I help you now?"

People who lack capacity 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

We found that the service had submitted DoLS applications for people, and renewal requests for authorisations that were out of date. These applications had been submitted and had yet to be processed by the local authority.

The deputy manager told us about plans to enhance the gardens to make them more welcoming, attractive and relaxing for people. They told us they were developing a reminiscence area complete with phone box, which they had already sourced, and picnic areas. They were hoping to have this area ready for the summer so people could enjoy it this year.

Good

Is the service caring?

Our findings

We received positive comments and feedback from people using the service and from relatives. People told us they felt respected and that staff were mostly considerate, kind and thoughtful. Comments included, "They are brilliant here absolutely brilliant," "Carers are all very nice" and, "The carers here are so good and gentle."

Everyone we spoke with told us that care staff were mindful of their privacy and dignity. We were told, and observed that, staff always knocked before entering rooms. We saw examples of staff caring for people with gentle and respectful approaches.

Staff understood people's needs and life histories. We heard staff chatting with people about families, previous lifestyles and experiences. We also read entries in the care records in the 'life story' or 'what is important to me' sections. With people's agreement, these included details of where people grew up, their education, jobs, family and friends. For one person their 'what is important to me' included details of their personal appearance and visits from friends.

Staff spoke to people in a friendly manner and people looked relaxed and comfortable in the presence of staff. We heard lots of banter that suggested there was a good relationship between people living in the home and the staff who supported them. Staff were interested and also chatted to people about day to day activities. We heard staff ask one person who had been out of the home during the morning "What was it like then? Have you had a good time?" The person responded with smiles and discussed where they had been and how they had enjoyed going out that morning. We heard a member of staff comment to another person, "You look very smart today, but you always make such an effort don't you, to look good." The person smiled and was clearly delighted.

People's equality and diversity was recognised and respected. We saw no evidence of practice that could be seen as discriminatory. People's preferences for gender of staff to provide personal care was respected and spiritual and religious beliefs had been discussed. People were supported to attend church services if they so wished. People were provided with information about the home. A newsletter was circulated to people that provided reminders about events, festivals and holidays and these were celebrated in the home. People's rights to a family life were respected and encouraged. Visitors were made welcome at any time and often stayed to enjoy a meal with the person living in the home.

We spoke with a person who was partially sighted. They told us about some of the day to day difficulties they experienced. We spoke with the registered manager who had already taken action and was in the process of trying to obtain an attachment for the television that would enhance the images on the screen and make it accessible for the person.

Staff reassured and offered support to people when needed. We heard one person asking if the member of staff could help them. The member of staff replied, "Are you ready? Let's stand up then and I'll help you along." The person smiled and said, "Just need my bag and my frame and I'm ready." The member of staff

helped the person out of the dining room, smiling and chatting as they walked together to the lounge area. Another person in the lounge looked anxious and clearly didn't want anyone to sit in the chair next to them. A member of staff reassured them by saying, "You want this saved for your friend don't you. She'll be along in a minute, she's just popped out to the ladies."

A member of staff said, "I think we give fantastic care and would I be happy for a relative of mine to live here? Yes I would," whilst another commented, "We are known for the good care we give. Even at the hospital they say this is a good home." A member of staff who had worked in the home for just a short period of time told us, "What makes it good here is that people are really listened to, and we take on board people's views."

We read recent compliment cards and letters received in the home. They included the following, 'I would like to thank you all for your patience with him,' 'The personal approach to the care and support for our mother on a daily basis has definitely contributed to her well-being and quality of life' and, 'My Mum has been coming to Edgehill Care Home for a few years for respite care and I cannot fault the care she has received'. We also read feedback entered onto the carehome.co.uk website. A range of positive comments included feedback about the staff and quality of care provided.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans showed that people and their relatives were involved in the care planning and the care planning review process. Before new people moved into the home they were assessed by the registered manager or deputy manager to make sure their care needs were known. People were also invited and encouraged, where possible to visit the home before they made the decision to move in. They often spent a morning or an afternoon to see if they liked the home and that it was suitable for their needs.

Care plans were designed to reflect individual needs. They included details of people's physical, mental, emotional and social needs. Care records were checked and reviewed by care staff every month. Care plans were formally reviewed every six months with involvement of people and their representatives to check they were still current and to make changes if needed.

Care plans provided details of people's preferences, and people were able to exercise choice and control. For example, for one person their records stated they liked to go to bed at 6.30pm. The person told us that staff respected this was their choice. They also told us that staff also checked regularly to make sure this continued to be what they wanted. They told us, "I am happy with this." For another person their records confirmed they were, 'Able to choose what he wants to wear each day.'

Overall, people were mostly satisfied with the care they received and felt their needs were being met. One person commented, "Everything is hunky dory here. And everyone is nice." We did receive feedback from people, relatives and staff about the lack of regular activities, entertainment and opportunities for people to go out of the home. In addition, there had been a viral outbreak in the home in December and visitors were informed of the risks of visiting during this time. This had resulted in, as one person commented, "Disrupted routines here." Two relatives told us that there were limited social opportunities for people who stayed in their room.

The registered manager told us they were currently recruiting for activity coordinator posts. They told us they engaged with the local community and entertainers regularly came into the home. They acknowledged the impact of the home being closed for a period of time, especially over the Christmas period had affected everyone, staff included.

A senior member of care staff had been allocated to organise and provide activities. They were enthusiastic and told us about the activities they had planned and organised. On the days of our visit, we saw bingo taking place, the member of staff spent some time with people in their rooms and took a couple of people out to the local community centre for a line dancing class.

During our visit, the homes' appointed 'dignity champion' had also organised an afternoon event for people who used the service, relatives and friends party to celebrate national 'Dignity Day'. This is an event aimed at reinforcing people's rights to dignity in care. An entertainer sang whilst people enjoyed drinks, including sherry and wine. A prize raffle was held and a high tea of sandwiches, scones and cakes were served on

tiered cake stands. During the afternoon people were asked what was important to them in relation to being treated with dignity and respect. The responses and quotes were hung on a dignity tree located in the reception area. The registered manager told us they planned to feedback the responses to staff at the next staff meeting to further reinforce the importance of treating people in care with dignity and respect and what it actually meant for each person.

Links had been developed within the local community. The registered manager and the deputy manager told us about the local library service that visited each month, local school children visited at Christmas and Easter, a 'mums who care' group organised presents for people who did not have friends or family nearby. A local business had hosted a christmas lunch event that was attended by 12 people. A couple of people regularly went out to the local pub for a meal, and often went out to events at the nearby supported living housing complex. They also told us they currently had three volunteers who regularly visited the home to support and befriend people. They had invited a visitor from a local service that provided support and advice for older people to discuss the possibility of the home becoming a 'pilot' for the introduction of a befriending people in care homes scheme.

A complaints procedure was in place that was readily available to people and relatives. We looked at the complaints file and saw that no complaints had been received in 2017. The registered manager told us the management team spoke to people and their relatives regularly and acted on comments, suggestions and feedback before people felt they needed to complain. The people and relatives we spoke with felt confident they could raise issues of concern if they needed to.

Consideration had been given to people's end of life wishes. Where there were agreed 'do not attempt cardio pulmonary resuscitation' instructions, (DNACPR), these were recorded in people's care plans. We saw where people had expressed specific wishes these were recorded. There was also guidance about people's wishes that stated, 'Is advisory only and may not be applicable if the resident's wishes or clinical condition changes or a situation arises that is not anticipated.' There were close links with the local hospice and the registered manager told us they received support, guidance and direction from staff at the local hospice when needed.

Requires Improvement

Is the service well-led?

Our findings

Systems were in place that identified shortfalls. A range of audits and monitoring checks were completed by the registered manager, senior staff in the home and the operations manager. For example, the operations manager visited the home on a regular basis to review performance and care quality provision. Audits and checks included infection prevention and control, health and safety, staff file checks, medicines audits and nutrition and hydration. Required actions were incorporated into an action plan.

We found improvements were needed to make sure shortfalls, such as those we reported on in the safe section of this report, were identified and acted upon. For example, the quality assurance system had not identified the significant number of shortfalls we found in the management of medicines. Systems had also failed to identify the shortfalls we found with cleanliness of commodes. The quality assurance system had identified shortfalls in the completion of monitoring records in September 2017. The operations manager had requested the registered manager and the deputy manager to complete daily checks to make sure the records were fully completed.

We acknowledge there had been significant short term challenges in December 2017 and January 2018, with a viral outbreak that affected people living in the home and staff. In addition, the registered manager had recently returned to the home following a period of leave. However, we have identified a breach of the regulations that also shows shortfalls in the quality assurance system. This means the rating for this section cannot be more than requires improvement.

The registered manager and the operations manager immediately compiled an action plan, before the end of our visit, to confirm the actions they were taking and had taken in response to our findings. Following our visit, they confirmed they had referred the medicine error to the local authority safeguarding team. They also held a senior staff meeting to reinforce the importance of safety in medicines management to the staff team.

People spoke positively about the management arrangements and knew who the registered manager and the deputy manager were. Their views and those of their relatives were sought as part of the quality assurance process to make improvements to the service. There were a variety of ways in which they could give feedback. These included annual surveys, residents' and relatives' meetings, care reviews and through the complaints process. We saw people had commented in one meeting about the time staff took to answer call bells during a specific time period in the afternoon. The registered manager changed the staff shift pattern and people had noted improvements.

Staff understood their roles and responsibilities and communicated well. They told us they enjoyed working in the home and were well supported by the management team. Comments included, "Love the staff and management. We have boundaries but we're so well supported" "We all pick up extra shifts because it's appreciated and we want the best for the residents" "My heart is here. It's been tough recently but I love it" and, "It's not just the staff that work hard here, it's the manager's too and we really appreciate that."

Staff had the opportunity to express their views at general staff meetings. Minutes were recorded and circulated. Staff told us they felt able to express their views and felt listened to. The provider's CEO attended a meeting with staff in November 2017. They followed up the meeting with a letter to all staff. The letter showed that staff had been given the opportunity to discuss their pay and working conditions with the CEO confirming actions being taken in response. They also responded to staff concerns about the lack of activity provision. It was acknowledged, due to increasing dependencies of people in the care home, the existing staff teams were no longer able to provide the level of activity and engagement people expected and needed. They confirmed the roles of activity coordinators were being introduced into the home. This showed the provider listened to feedback and was committed to making improvements to the service.

The registered manager was able to tell us how they kept up to date with current practice. They also told us they were provided with information and guidance from the provider. The register manager told us they attended local provider forums. The provider arranged annual conferences and quarterly training and development and meetings which were two day events. The registered manager told us they took opportunities to use the resources of Skills for Care, a nationally recognised workforce development organisation.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.

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 Medicines were not safely managed.