Countrywide Care Homes (2) Limited

Garden Hill Care Centre

Inspection report

32 St Michaels Avenue
South Shields
Tyne and Wear
NE33 3AN

Tel: 01914975255

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 5 and 6 December 2018. This meant the staff and provider did not know we would be visiting.

Garden Hill Care Centre is a care home that provides accommodation and nursing or personal care for a maximum of 40 older people and younger adults, including people who may live with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodated 37 people at the time of the inspection.

A manager was in post who had applied to become registered with the Care Quality Commission. At the time of writing the report they had become registered. 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.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person-centred care, safe care and treatment, staffing and governance.

You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe. However, staffing levels were not sufficient and staff were not appropriately deployed around the home to ensure people's needs were managed safely and in a person-centred way. People said staff were kind and caring. However, we saw staff did not always interact and talk with people. There was an emphasis from staff on task-centred care.

A programme of activities was available but activities provision was not well-organised around the home. Staff did not have time to carry out activities when the activities co-ordinator was not available.

Records did not reflect the care provided by staff. They lacked evidence of regular evaluation and review to keep people safe and to ensure all staff were aware of people's current care and support needs. Care plans did not provide guidance to ensure all people were supported in a person-centred way.

Staff received training, supervision and support. However, systems were not in place to ensure all staff who provided specialist care had received the required training to ensure they had the skills and were competent to deliver the care safely. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives. However, improvements were required to ensure staff supported them in the least restrictive way possible.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. Staff received training and they were supervised and supported

People had access to health care professionals to make sure they received any specialist care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way. People received a varied and balanced diet to meet their nutritional needs.

People's dignity was not always respected. Communication was effective to ensure staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and family members.

Changes were being made to the environment. It was being refurbished. There was a good standard of hygiene and improvements were being carried out to the building keeping disruption to a minimum where possible.

A robust quality assurance system was not in place to assess the quality of the service. Audits that were carried out were not effective as they had not identified issues that we found at inspection.

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.

Although people told us they felt safe, systems were not in place to ensure their safety and well-being. Systems were not all in place to minimise risk to people's health and safety.

Staffing levels were not sufficient and staff were not appropriately deployed to ensure people were looked after in a safe, effective and person-centred way.

Staff were appropriately recruited. Checks were carried out regularly to ensure the building was safe and fit for purpose. There was a good standard of hygiene around the home.

People received their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People received a varied and balanced diet. However, improvements were required to monitor the fluid intake of people and to ensure any staff who delivered specialist feeding to people had the appropriate skills and knowledge.

Staff received supervision and training to support them to carry out their role. The environment was well-maintained and there was a programme of refurbishment.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and caring but there was an emphasis on task-centred care as there was limited interaction with people by staff.

People were encouraged to express their views and make decisions about their care. People were supported to maintain contact with their friends and relatives. Staff supported people to access an advocate if required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Regular staff were knowledgeable about people's needs and wishes. However, records did not reflect the care provided by staff.

People had limited opportunities for activities when the activities organiser was not available.

People had information to help them complain. Complaints were recorded and information was available to show the action taken where a complaint had been received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A manager was in place who was in the final stage of registration with CQC at the time of inspection. They were registered by the time of writing the report.

People, staff and relatives told us the manager was supportive and could be approached at any time for advice and information.

The registered manager and provider monitored the quality of the service provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received safe care that met their needs.

Garden Hill Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out the inspection as we had received information of concern about the service which included about the quality of care and staffing levels.

This inspection took place on 5 December and 6 December 2018 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert-by-experience on day one of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. Day two of the inspection was carried out by an adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with nine people who lived at Garden Hill Care Centre, 10 relatives, the

manager, the regional manager, two registered nurses, the cook, kitchen assistant, six support workers, the activities co-ordinator and one visiting professional. We looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for seven people, recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, quality assurance audits and other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Most people, relatives and staff commented there were insufficient staff to support people safely. Their comments included, "Staffing levels are horrendous", "Staff do care but they are overworked and overstretched", "It's a good place but they need more staff", "They are desperate for more staff", "There are staff shortages", "There are serious problems with staffing levels, people aren't getting the attention they need because of this", "[Name] is left alone for long periods and gets no social interaction", "There are a lot of agency staff who don't seem to know the people here. I have seen one give [Name] a very hot cup of tea from an inappropriate cup" and "It is difficult to find staff."

Our observations over the two days of inspection showed that staffing levels and staff deployment were not well-managed to ensure safe and person-centred care to people in all parts of the home. Across the three floors of the home there were two nurses and six support workers deployed. The manager informed us one person received 1:1 support at all times due to the risk of choking. However, they told us they had not accounted for this separately when looking at staffing numbers. Therefore five support workers were available to support 36 people. We were informed this number reduced in the afternoon as a support worker went off duty at 2:00pm and was not replaced. Therefore, from 2:00pm, four support workers were available to support 36 people with the fifth support worker providing 1:1 care to a person. We were told nursing staff provided direct care to people. However, this was not observed during the inspection, the nurses being responsible for paperwork, mentoring, supporting agency nurses, medicines, healthcare, liaising with other professionals and relatives and the running of the floor. We observed the medicines rounds took some time, due to some people's complex needs, which also gave less time for nurses to provide direct care to people.

It was observed the ground floor was staffed by two staff members and accommodated six people, although some people from other floors came to the ground floor during the day with no additional staff support. The middle floor was staffed by one nurse and two support workers, one of the support workers providing 1:1 support to a person and the other 15 people, including people who were cared for in bed. Some people who required total assistance and regular positional turns were supported by one support worker. The top floor accommodated 15 people. 10 people were cared for in bed and they were supported by one nurse and two support workers. Support staff were not allocated to a specific floor and during periods of the day it was observed staff were not apparent on the middle and top floor. Several buzzers rang for long periods of time. We observed a nurse call activated by a staff member for a person receiving 1:1 support sounded for over 15 minutes.

Observations during the inspection showed that when staff were busy other people had to wait and were left unsupervised. On occasions people became distressed as they waited for staff assistance. To the middle and top floor of the home people confined to bed did not receive staff interaction unless they were receiving personal care. We had concerns that some people were in bed as staff were not available to support them to get up. We intervened with one person, who was in bed, and went to see why they were distressed as staff were not available. They told us they did not want to be in bed, we observed next morning they were much happier and they were up from bed and dressed. We discussed our concerns about staffing levels and staff deployment with the management team at the end of the first day of inspection. At the beginning of day two

we were made aware that staffing levels had been increased as a new admission was being made urgently. However, our findings showed staffing levels were not sufficient and they were not consistently maintained to ensure people receive safe and effective care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us accidents and incidents were monitored. Individual incidents were reviewed and a monthly analysis was carried out to look for any trends. They told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls or behaviour management. However, we had concerns that 257 falls had been logged since January 2018 and a number of them had been unobserved. Fortuitously people had not suffered serious injury but the high numbers of falls provided evidence that people were not being appropriately supported and supervised to keep them safe. Improvements had not been made by management despite their incident analysis of the recurring numbers of falls.

Staff had undertaken safeguarding training about how to recognise and respond to any concerns. Safeguarding records showed 34 safeguarding alerts had been made since January 2018. They included service user incidents and allegations of poor care that had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

Observations during the lunchtime period showed that people cared for in bed did not all receive assistance with their meal or supervision where their care records stated they were at risk of choking as their food was served to them and staff left the room.

Our observations showed not all people had access to a nurse call, where they were able to use them. We noted they did not all work and we advised a more regular check should be carried out to ensure they were in working order so people could alert staff if needed.

We discussed with the management team what action the provider was taking to achieve compliance with the fire risk assessment that had been carried out by the fire authority in October 2018. We were shown some equipment that was waiting to be fitted. We considered that more timely action needed to be taken to ensure the fire authority's requirements were carried out so people throughout the home were kept safe from the risk of fire.

Care plans were not in place for all people to provide detailed guidance for staff for the management of behaviours that challenged. For example, when a person may become agitated or distressed. Care plans were vague and did not document what staff needed to do, to recognise triggers or de-escalate the situation to calm and reassure the person when they were agitated or upset. We discussed this with the manager who told us it would be addressed.

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

People's individual risk assessments were in place with a system of review. The risk assessments included risks specific to the person such as for moving and assisting and pressure area care.

Records showed the provider had arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out such as for checking the fire alarm. External contractors

carried out regular inspections and servicing. For example, fire safety equipment, electrical installations and gas appliances.

People received their medicines in a safe way. A relative commented, "Staff are spot on with [Name]'s medicines, even if they refuse, staff persuade [Name] with kindness." Staff had completed medicines training and had access to policies and procedures to guide their practice. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines.

There was a good standard of hygiene around the home. Staff received training in infection control and protective equipment was available for use by staff as required.

Robust recruitment processes were in place to ensure staff were safe and suitable to work with people. Recruitment files showed appropriate checks were completed before they started employment. This included proof of identity, criminal history checks, references from prior employers, job histories and health declarations. This helped to ensure only suitable people were employed to care for vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

People who were at risk of poor nutrition received some support to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. However, electronic records showed there were gaps in recordings. Food and fluid charts were not completed daily for some people to ensure accurate recording and monitoring of people's food and fluid intake. Some fluid charts showed people were not being offered regular drinks. They also did not show what action was taken when the amount taken did not correlate with what they were supposed to drink. We discussed with the manager that food and fluid charts for monitoring intake, did not accurately reflect the amounts people had eaten or drunk for monitoring purposes. We discussed the lack of a visual prompt for staff as a paper record for food, fluid and positional charts were not available for staff to complete for people who were cared for in bed to ensure staff provided appropriate care. We also noted in the complaints log some complaints had been received querying if people were receiving appropriate support with regard to their food and fluid intake.

Observations showed support staff were involved in specialist feeding to people who may require Percutaneous Endoscopic Gastrostomy (PEG) feed. (PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines.) However, discussions with staff and records showed not all staff had received the specialist training and some had been shown by other support staff how to feed a person by this method. We had concerns that not all staff involved in this type of nutritional feed had received the necessary specialist training and been signed off as being clinically competent so they knew how to deliver a person's care and treatment safely when they were fed by PEG.

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

Systems were in place to ensure people received varied meals at regular times. People's comments included, "The meals are very good here", "The food is fantastic", "Meals are being changed to offer more variety" and "There's plenty to eat." We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us the menus were being changed and they were taking photographs of meals to show people to help them make a choice.

We observed the lunch time meals in the dining rooms. People enjoyed a positive dining experience. People were offered a choice of meal and drinks. People sat at tables that were well-set and people were offered protective aprons. No one was rushed and people could eat their meal at their own pace. Staff were supportive to people and offered full assistance as required.

Staff were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up-to-date with training and that training was appropriate. Their comments included, "My training is up-to-date", "I'm going to do end-of-life training", "We do classroom training and e learning" and "I've just had supervision." A relative told us, "Staff seem well-trained to use the equipment."

Staff told us when they began working at the service they had completed an induction programme and had

an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work.

People's needs were assessed before they started to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

People were supported to have their healthcare needs met. Their care records showed they had input from different health professionals. For example, the GP, speech and language therapist (SALT) and positive behaviour team. One relative told us, "[Name] sees the GP, they come and visit them."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that DoLS applications were clearly documented and where people were being restricted then this was done in their best interests and the least restrictive option was always considered.

The home was being refurbished and some communal areas and bedrooms had been re-decorated and flooring replaced. At the time of inspection, the ground floor lounge was being re-decorated. The manager told us refurbishment was on-going. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms were signed for people to identify the room to help maintain their independence.

Requires Improvement

Is the service caring?

Our findings

We saw staff were busy and did not have the time to talk to people and spend time listening to what they had to say. We observed many staff only engaged and interacted with people when they were carrying out a task with a person. For example, when they provided personal care or at meal times. People on the ground floor received more stimulation and the atmosphere was lively and busy. Care was task-centred rather than person-centred. This meant support workers carried out tasks with people rather than attending to them at a time they may choose and spending time interacting with them. Staff told us they were kept busy and did not have time to spend with people. We discussed with the manager, the impact of the inadequate staffing levels that staff were busy and did not have time to interact with people except when they provided care and people's support. Also that people's dignity was not respected as they were not attended to in a timely manner and may become incontinent as they waited due to staff deployment and staffing levels.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff appeared to have a good relationship with people and knew their relatives as well. The majority of people and relatives we spoke with said staff were kind, caring and patient. Their comments included, "The majority of staff are very caring", "The staff are great, but very busy", "I have seen staff treat [Name] in the way I think they would treat their own relative", "I do think staff care", "Staff do care, they are always willing to help" and "Staff take the time to get to know you when they have time."

Staff engaged with people in a calm and quiet way when they interacted with them. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the inspection, when staff did interact with people, the interactions we observed were friendly, supportive and encouraging.

People's privacy was respected. We observed staff were respectful when they engaged with people. Staff knocked on people's doors before entering their rooms, including those who had open doors.

People's care records contained information about people's likes, dislikes and preferred routines. Records captured information about people's previous hobbies and interests to help inform staff when the person was unable to tell staff about their routines and how they wanted their care to be delivered.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information was accessible and was made available in a way to promote the involvement of the person.

People told us they made their own choices over their daily lifestyle. For instance, people had the opportunity to have a lie-in. They told us they could go to bed when they wanted and staff respected their wishes.

Written information was available that showed people of importance in a person's life. People were encouraged and supported to maintain and build relationships with their friends and family. Where people did not have family, staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. Information about independent advocates and advocacy services was displayed. Advocates can represent the views of people who are not able to express their wishes, or have no family involvement.

Requires Improvement

Is the service responsive?

Our findings

Staff were mostly knowledgeable about the people they supported. However, records were not all in place and completed regularly to accurately reflect people's care and support needs. An electronic system of record keeping was in place but it did not ensure records maintained were accurate and relevant.

Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Care plans were not person-centred to ensure staff had guidance about how to deliver care and support in the way the person needed and wanted. Care plans did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted.

For some people records did not reflect their current support needs. For one person with a debilitating medical condition, a care plan was not in place to provide guidance to staff about how to support the person. Staff were referred to a pamphlet about the condition to find out how best to support the person which they could interpret themselves in order to provide care. A relative told us about a person who had fallen and broken their wrist. However, the care plans for the person, such as for nutrition, had not been up-dated to show the additional support they required when eating. For another person we observed a safety gate was placed across their doorway. This was not appropriate as it was a physical restraint. We discussed this with the manager who told us it was requested by the person because a person kept wandering into the room, when we checked the person no longer lived at the home. A care plan also was not in place that referred to the use of a safety gate.

Records did not show that monthly reviews of assessments and people's care plans took place. They showed not all records had been reviewed. They also did not all reflect the changes that had taken place to provide an accurate account of people's progress and well-being.

The manager also told us some people refused personal care interventions. Records did not reflect where people refused support and care plans were not in place to provide guidance to staff if people did refuse any support.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Several people were being cared for in bed but records did not show why they were being cared for in bed or when or if they got up. We were told a person was receiving end-of-life care this was not reflected in the person's records. There was no information to show when the person's needs had changed or when they had started receiving end-of-life care.

Charts were also completed to record any staff intervention with a person. For example, for recording when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information to give an overview of people's well-being over the 24-

hour period. Records showed these charts were not always completed daily for some people to record any staff intervention with them. For example, for recording when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. There were gaps in recordings which suggested people did not receive regular personal hygiene. We discussed this with the manager.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An activities person was employed. They told us they worked full time and occasional Saturdays. They provided one-to-one as well as group activities with people. People and relatives confirmed some activities, seasonal entertainment and parties took place. Activities included, relaxation exercises, bingo, board games and quizzes, arts and crafts, reminiscence, virtual reality, church services and coffee mornings. We observed activities took place on the ground floor on the two days of inspection but not with people on the other two floors of the home. People from other floors of the home were supported downstairs and congregated on the ground floor in the coffee shop and other communal areas. People in their bedrooms did not receive engagement from staff apart from when they received care. We were also told that the activities person was responsible for escorting people to hospital and was involved in direct care support such as assisting people to the bathroom. One relative told us, "There were no activities last week." Another relative said, "There are no real activities. The activities person takes people to hospital and other duties, as staff are busy. If they are doing that they aren't doing activities." This meant they were then not able to provide activities. Staff were busy and observed not to carry out activities when the activities person was not available. We discussed this with the manager as part of the discussion about inappropriate staffing levels. They told us it would be addressed.

Records showed the relevant people were involved in decisions about a person's end-of-life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs.

People knew how to complain. Relative's comments included, "We have had some small complaints in the past, they were dealt with promptly" and "We've never had to complain." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and 25 complaints had been received since January 2018. The records showed they included concerns about people's care including nutrition, hydration and pressure area care. Records showed they were investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

Two registered managers had managed the home since the last inspection and consistent leadership would not have been provided with the changes in management. The current manager had become registered with the Care Quality Commission at the time of writing the report.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. However, the audits had not highlighted issues we identified at inspection. These included inadequate staffing levels despite the numbers of falls, complaints, safeguardings and comments from staff, relatives and people who used the service. Records audits had not highlighted deficits in record keeping. This included care plans, evaluations and daily accountability records for people such as food, fluid and personal hygiene records. Audits of records did not ensure they contained accurate and detailed information so people received appropriate and safe care in the way they wanted and needed.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The audits consisted of a range of daily, weekly, monthly, quarterly and annual checks. They included the environment, health and safety, medicines, infection control, finances, safeguarding, complaints, personnel documentation and care documentation.

The regional head of quality and compliance (North) manager told us they carried out regular visits to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, medicines records, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check that appropriate action was taken as required.

The manager and regional manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The manager was able to highlight their priorities for the future of the service and was open to working with us in a co-operative and transparent way.

Staff said they worked as a team. Staff were positive about the new manager of the service and had respect for them. Several staff members said they "felt supported." Other comments included, "The manager listens" and "The manager comes out of the office to see what's happening around the home."

People and their relatives were positive about management. One person commented, "We have had a new manager appointed recently, they seem to know what they are doing." People were kept involved and consulted about the running of the service. A variety of information was displayed to keep people informed and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at

the beginning and end of each shift. There was also a handover record that provided some information about people, as well as the daily care entries in people's individual records.

Staff told us staff meetings took place and minutes of meetings were available for staff who were unable to attend. One staff member commented, "Yes, we do have staff meetings". Staff meetings kept staff updated with any changes in the service and to discuss any issues.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and staff.

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 9 HSCA RA Regulations 2014 Person-centred care People received task-centred care and systems and records were not in place to ensure people received person-centred care at all times. Regulation 9(1)(3)(b)

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 Systems were not all in place to mitigate risk and to ensure people received safe care and treatment. Regulation 12(1)(2)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing

Treatment of disease, disorder or injury

levels were sufficient and staff were appropriately deployed to provide safe, timely, effective and person-centred care to people at all times.

Regulation 18 (1)