Purelake Healthcare Limited

Ashley House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 March 2016 and was unannounced. At the previous inspection on 9 July 2014, we found there were no breaches of legal requirements.

Ashley House provides accommodation with personal care for up to 17 older people living with dementia. There are 15 single and one double room available. There were 15 people living at the service at the time of inspection and everyone was living in a single room. The accommodation is over two floors and bedrooms can be accessed by a passenger lift. There is a communal lounge at the back of the home with access to a secure garden. There is also a separate dining room where most people eat their meals.

The service has a registered manager who was available and supported us during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Medicines controlled under the Misuse of Drugs Act 1971 to prevent them from being misused and causing harm, were not stored securely at the service. There were no protocols in place for people who were prescribed their medicines to be given 'as required'. There was no guidance in place for staff to follow to maintain the health of people with diabetes.

The hall and stair carpet was worn, had a number of small holes and a patch by the dining room door, which posed a tripping hazard. The provider was aware of the hazard, but had taken no action to address it to make the environment safe.

Each person had an individual plan in place detailing how to evacuate them in the event of a fire. However, the equipment needed to evacuate one person safely, was not available at the service.

Around half the staff team had not received training in areas essential to their role, including safeguarding, health and safety, fire prevention, infection control, moving and handling people safely and The Mental Capacity Act 2005 (MCA). The service specialised in supporting people living with dementia but care staff had only received basic training in this area and had received no training in how to effectively support people with behaviours that may challenge themselves or others. There was no plan in place which identified when these training gaps would be met.
There was not an effective quality assurance process in place and the provider did not respond to shortfalls identified in the service in a timely manner.

People had their health needs assessed and monitored and professional advice was sought as appropriate. People were offered a choice at mealtimes, and where appropriate support was provided and people were not rushed.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager had consulted the local authority with regards to making DoLS applications, so people were not deprived of their liberty unnecessarily.

Staff said there was good communication in the staff team, that they felt well supported and received regular formal supervision with the registered manager.

Checks were carried out on all staff to ensure that they were fit and suitable for their role. Staffing levels ensured that staff were available to meet people's needs. Staff knew how to follow the home's safeguarding policy in order to help people keep safe.

The home was clean and staff knew what action to take to minimise the spread of any infection.

People, visitors and professionals gave positive feedback about the compassionate and caring nature of the staff team. Staff were kind and caring and communicated with people appropriately using touch. Staff valued people, showed concern for their well-being and involved them in decisions about their care.

People's care, treatment and support needs were assessed before they moved to the service and a plan of care developed to guide staff on how to support people's individual needs. Information had been gained about people's likes, and past history and staff had a thorough understanding of people's choices and preferences.

People and visitors knew how to raise a concern or complaint, but said they had not needed to do so.

The registered manager was passionate about providing a personalised service for people and led by example. Quality assurance feedback was sought from people, relatives and professionals.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some medicines were not stored securely and there was no guidance in place for medicines prescribed for people to be taken 'when required'.

Risks to people's health and safety had not always been assessed nor action taken to minimise their occurrence.

People were protected by robust recruitment practices and there were enough staff available to meet people's needs.

Staff knew how to recognise any potential abuse and this helped keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not all received the essential training they required to support the people in their care.

Staff gained people's consent before supporting them with their care or treatment.

People's health care and dietary needs were assessed and they had access to healthcare professionals when needed.

Meal times were managed effectively to make sure that people had an enjoyable experience.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and communicated with people in an individual and affectionate manner.

People were treated and valued as individuals.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved to the service and staff were provided with guidance so they knew how to support them.

People were offered a range of one to one and group activities that met their needs and preferences.

People and relatives felt confident to raise a concern or complaint if it was necessary.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes were not monitored effectively to result in consistently good quality care.

The registered manager was clear about the vision and values of the service, which they effectively communicated to the staff team.

People and their visitors were provided with forums where they could share their views and concerns.

Ashley House

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 16 March 2016 and was unannounced. Three inspectors carried out the visit.

We did not send the service a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

We spoke to ten people who lived at home and three relatives/visitors. We spent time in the lounge, observing how staff interacted with people and joined some people for lunch. We spoke to the registered manager, deputy manager, two senior staff, the chef, housekeeper and maintenance man. We received feedback from a district nurse, visiting dentist and two care managers from the local authority.

During the inspection we viewed a number of records. We looked at the care notes in relation to five people and spoke to four of these people and/or their relative, and staff, to track how people's care was planned and delivered. We viewed the provider's policy and procedures file, which is accessible to all staff. We also looked at other records including the recruitment records of the three staff employed at the service; the staff training programme; administration and storage of medicines, complaints log, staff and residents meetings, menu, health and safety and quality audits, and questionnaire surveys.

Requires Improvement

Is the service safe?

Our findings

People and their relatives/visitors said that people were safe living at the service. One person told us, "its lovely here. I feel safe here and the girls will help me with things I need". A relative told us, "When I go on holiday I know my relative will be safe". A social care professional told us that the service was "proactive" in taking action to keep people safe when any safeguarding issues had been raised. They said that the service ensured that the safety and well-being of people living at the service was paramount. However, we found there were areas where people's safety was not always assured.

Medicines controlled under the Misuse of Drugs Act 1971 to prevent them from being misused and causing harm, were not stored securely at the service. The lock on the cupboard was broken and therefore the security of these medicines was compromised even though this had been reported to the provider on successive monthly reports. Controlled medicines were at risk of theft, tampering, misuse or spoiling because the provider had failed to ensure their safe storage.

The medicines policy stated that there should be a clear protocol in place for people who were prescribed their medicines to be given 'as required' (PRN). However, these instructions were not always available to staff. Some people had been prescribed medicines for the control of diabetes. However, there were no instructions in place about the circumstances when staff should administer this medication. Therefore, it could not be assured that people were receiving their medicines when they were required.

There was no risk assessment in place which set out the extra support, monitoring and observations that people required who were prescribed medicines which had a variable dosage. Therefore, staff may not recognise the possible side effects of this medication on the person, so that they could take the appropriate action to maintain their health.

These shortfalls in the management of medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a medicines policy which gave guidance to staff about the storage, administration and disposal of medicines. Only staff who were trained administered medicines and they understood the importance of accurate record keeping. Staff were aware of people who may have difficulties taking their medicines and knew how to seek appropriate help when this was required. Staff explained to people that they were giving them their medication, observed that they took them, and then signed the medication sheet, to record what medicines they had taken. When people were given controlled drugs, two members of staff checked to make sure the correct medicines were given, as an added precaution.

Regular checks were made of the service's equipment and utilities to ensure they were safe and adequately maintained. The registered manager had highlighted in management reports to the provider that the hall and stair carpet was in need of replacement since July 2015. The stair carpet was very worn by the treads and was at risk of wearing away, creating a serious trip hazard. There were also a number of small holes in the hall carpet. Of particular concern was the area by the dining room door where a patch had been placed

over a hole in the carpet. Patching a carpet is a temporary fix as the patch cannot be sustained with a high level of wear and the resulting area will become a trip hazard. However, the provider had taken no action to address these safety concerns.

The lack of action to address potential hazards in the environment is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Personal emergency evacuation plans (PEEPs) had been put in place which identified the support people needed to be evacuated in the event of a fire. However, these plans had not been reviewed when people's needs had changed. One person's bedroom was on the first floor and they required a hoist and wheelchair to mobilise. An assessment of the support and equipment this person needed to be safely evacuated from their room had not been undertaken. Therefore it could not be assured that they could be evacuated quickly and safely in the event of a fire.

Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as their risk of falling, malnutrition, self-neglect and of developing pressure areas. Guidance was in place for staff to follow about the action they needed to take to make sure people were protected from harm. However, there were some shortfalls in this area. For people with diabetes, a risk had been identified that they may have too much (hyperglycaemia) or too little sugar in their blood stream (hypoglycaemia) and people's blood sugar levels were checked on a regular basis. However, guidance was not in place about what staff should do if a person was hyperglycaemic or hypoglycaemic. We asked staff what they should do and they knew what to do if the person had too little blood sugar, but not what to do if their blood sugar level was too high. Therefore, it could not be assured that staff would take the appropriate action to maintain people's health

Incident and accidents were recorded but not all events had been analysed and action taken to prevent their reoccurrence. When some people had fallen action had been taken to minimise the reoccurrence. However, when other people had fallen, it was not evident that action had been taken to identify the cause and so take action to prevent them falling in the future.

These shortfalls in assessing and managing risks to people's health and safety are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a detailed safeguarding policy in place that reflected the guidance of the local authority. Staff were clear about identifying the possible signs of abuse that would prompt them to speak to a more senior member of staff. Senior staff understood that safeguarding concerns should be reported to the registered manager and local authority, who are the lead agency in safeguarding adults.

People, visitors and social care professionals said there were enough staff around to meet people's needs. One person told us, "The staff here are very good. If you need anything or want to know something they help you straight away". Another person told us, "The staff are around when you need them". A relative told us, "There is a low turnover of staff and a number of staff have been here for a few years and so know me and my relative well". Staff were available to support people during the day and responded in a timely manner. A minimum of one member of staff was always present in the lounge, where most people chose to sit. A dependency tool had been used to calculate how many staff should be deployed to meet the needs of the people who lived at the home. Staffing rotas reflected the accurate number of staff who were on shift on the day of our inspection. Staffing levels for care staff, and auxiliary staff such as domestic workers and kitchen staff remained the same throughout the week and weekend.

Appropriate checks were carried out to ensure that staff recruited to the service were suitable for their role. This included obtaining a person's work references, a full employment history and a Disclosure and Barring Service (DBS) check.

People, relatives and visiting professionals said the home was always clean and odourless. Most staff had received infection control training and there were suitable supplies of personal protective equipment available. Staff used this protective clothing appropriately throughout the day of the inspection. The laundry room was small, but dirty and clean clothing was kept separately, to minimise the risk of any infection spreading.

Requires Improvement

Is the service effective?

Our findings

People said that staff took the time to sit and talk to them. Relatives said there was good communication in the service and that they were kept up to date with people's well-being. "Staff let me know straight away if there are any changes in my relative's medication or if they are unwell or not themselves". A social care professional told us that staff communicated well with people and relatives. They said that staff kept family members informed and that this gave them "Peace of mind". Everyone was positive about the effective support given by the staff team. A relative/visitor told, "The staff have the skills and patience to look after people. There is always a calm atmosphere here and staff know people well".

There were a large number of gaps in the staff training programme which indicated that not all staff had received training and updates in areas essential for their role. Therefore, the provider could not be assured that staff had the knowledge and skills essential for their roles. Around half the staff team of thirteen had not received training in safeguarding, health and safety, fire prevention, infection control, moving and handling people safely and The Mental Capacity Act 2005 (MCA).

The aim of the service was to support people living with dementia, but only eight out of thirteen care staff had received a half day training course in dementia, which was the same level as that for domestic staff. Care staff had not received any additional specialist training in this area. Specialist training enables staff to understand more about each person's unique experience with dementia and the different strategies to help support people effectively.

This lack of staff training in areas essential to their role is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans identified that some people could present behaviours that were challenging to themselves or other people. This included low level verbal and physical challenges. The nature of the person's behaviours was detailed, together with guidance for staff on what action to take to minimise the occurrence. Behavioural charts were in place to record the triggers to the event and the action taken by staff as a result of the incident. Staff explained this was to assess if there were any reoccurring triggers to the behaviour, so they could be minimised. Some people's behaviour had decreased since moving to the service. Professional advice was sought from the mental health team as required.

New staff completed an in-house induction which included gaining knowledge about the home's policies, safeguarding, emergency procedures and roles and responsibilities. They also shadowed senior staff to gain more understanding and knowledge about their role. In addition, new staff completed the Care Certificate. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised.

Domestic and care staff were encourage to complete Diploma/Qualification and Credit Framework (QCF). To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard. Ten out of thirteen care staff had completed levels two or above in Health and Social

Care.

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 the best interests and as least restrictive as possible. Staff understood that people had the capacity to make their own decisions and choices on a day to day basis, but sometimes this capacity fluctuated as people were living with dementia. They said that in these situations, they acted in the person's best interests. Staff spoke to people before supporting them and always obtained their consent before giving care. The registered manager had been involved in meetings with people, their family members and representatives. This was in order to make a decision for someone in their best interest, when they did not have the capacity to do so.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager had sought advice from the local authority about when applications should be applied to a 'supervisory body' to be considered and checked to ensure that the service was acting lawfully.

People said they were supported to have enough to eat and drink and were involved in decisions about what they eat and drank. Comments included, "I like the food"; "The food here is good and there's always enough to eat and drink"; and "They come and ask you what you would like to eat each day. Today I think it is either roast chicken or pasta. I have chosen the chicken as I don't like pasta".

People's need in relation to food and fluids were assessed and the support they required was detailed in their plan of care. There was a four weekly menu planner and at lunchtime people were offered a choice of two main meals. At tea time there was always a hot and cold option. A record was kept of the percentage of the meal that people ate so it could be identified if people were not maintaining a healthy diet. In addition people were weighed regularly. The chef was aware of who had special dietary requirements and also of the importance of ensuring that meals were balanced and included essential vitamins and minerals.

At lunchtime staff asked if people required any assistance such as help cutting up their food or using a spoon rather than a fork, if a person was finding it difficult to eat independently. Some people did not want to eat and staff encouraged them to take their time and to just eat a small amount. People were also offered alternative hot or cold options. Hot and cold drinks were available throughout the day. Drinks were placed within reach of people so they could drink when they wanted to.

One health professional told us that the service contacted them appropriately in order to maintain people's health. Another health professional told us that the service had a very good working relationship with visiting professionals and said that this is one of the best homes that they visited in their professional capacity. They said that any problems were dealt with straight away, that the standard of care was, "Very good" and it was a pleasure to visit the service.

People's care plans gave staff written guidance about people's health needs. These included information about people's medical conditions and medical history. Where it had been identified that people had specific health care needs, referrals had been made from health care professionals. For example, where people's skin integrity was at risk, the district nurse had been contacted for advice and pressure relieving equipment been obtained. A record of all health care appointments was made, such with the dentist,

optician, district nurse or doctor. This record included any advice that was given by the health professional.

Staff said that there was good communication in the whole staff team and that they worked well together. Staff said they could approach the registered manager to discuss any issues or concerns. Regular staff meetings were held in which staff said they were confident to raise and discuss any issues. The registered manager conducted formal supervisions and annual appraisals with all staff. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

Good

Is the service caring?

Our findings

People were very positive about the support they received from the staff team. Comments included, "It is jolly nice here. The staff are very kind and helpful"; "It's good here I really like it"; and "We all mix well here". Several people commented that they liked that there were always staff around to sit and talk to them. "Staff sit and talk to me about all sorts of things", one person told us. Relatives/visitors said they would recommend the service to others because of the caring atmosphere. One relative told us, "I would recommend the home as the staff are patient, caring and kind." Another relative/visitor told us, "The staff are very caring. It is a home and not a business. It is a home from home. The staff cannot do enough". A social care professional described the service as "A family environment" where everyone was included. Health professionals also stated that the staff communicated with people in a kind and caring manner.

Everyone told us that people were treated with dignity and respect. Staff discussed how they treated people with dignity and respect by referring back to how they themselves would like to be treated. Throughout the day staff talked to people about things that they were interested in such as the songs, films and cars. Staff engaged people in a positive and appropriate way that upheld people's dignity and respected their individuality. At lunchtime, staff discussed different foods with people.

Staff were kind and compassionate and communicated with people appropriately using touch. They listened to people and talked to them in an appropriate ay so they could understand. One staff member changed their voice when speaking to two different people. This ensured that each person could understand that the staff member was saying to them and this personalised approach clearly put both people at ease. People felt confident to show their affection to staff. One person kissed a member of staff's hand when speaking to them and the staff member responded with words and a smile.

Staff showed concern for people's well-being in a caring and meaningful way and responded to people's needs. One person was being transferred using a hoist. The person showed signs of worry and anxiety. Staff spoke calmly and reassured the person at regular intervals. They explained each step of the moving and handling process so they person knew exactly what was going to happen next. This helped to ease the person's concerns.

People were given explanations when required. One person rested their arm on a member of staff as reassurance that they would stay with them. When this member of staff needed to move and attend to another person, they explained that they were moving away to the other end of the room. They said they would sit back next to them as soon as they had completed their tasks. This person was reassured by this explanation.

People were involved in decisions about their care, such as what they wanted to wear and what they wanted to eat. People's right to change their mind was respected. At lunchtime, although people had chosen what they wanted to eat, some people changed their minds and were offered an alternative. For people who had been prescribed pain relief, staff involved them in their treatment, by asking them how many medicines they required.

People and their relatives had been contacted to obtain information about their past lives. This included people's past occupations and relationships that were important to them. Staff demonstrated that they knew people well, including their families, past occupations and personal preferences. When staff described people's current needs they also focused on people's strengths, such as their personality and responsibilities in their working lives. This showed that staff valued the people in their care.

Good

Is the service responsive?

Our findings

People said there were a range of activities available for them to join in. "There are two activity people. We do things like quizzes, bingo and throwing bean bags. There are lots of different things to do". Other comments included, "It is a good place to live as I can walk around when I like"; "I go into the garden in the good weather. I have sat out there in the sunshine and fallen asleep"; and II like it here as it is quiet". A social care professional said that there were a range of group and individual activities on offer.

Two part time activities coordinators were employed from Monday to Friday to provide one to one and group activities for people. Group activities included singing, board and card games, arts and crafts, bingo and quizzes. Staff also regularly talked with people on a one to one basis. On the day of the inspection, the activities coordinator was not present and a staff member carried out this role. In the morning people were asked if they wanted to join in a game of picture bingo, based on things that you could find at the seaside. Some people chose to take part and other people chose not to and their decision was respected. Staff sat next to people to help them join in the game. The member of staff also turned the bingo into a quiz at times, giving people clues as to what the next object found on the beach might be. This meant that people not taking part in the bingo also got a chance to join in with the game. During another activity one staff member supported three people to engage with the group activity using a personalised approach to different people in a kind and individualised way. In the afternoon people watched a musical. There was music on in the lounge at times throughout the day and at lunchtime for people to listen to. Some people enjoyed joining in and singing the words to familiar songs. At lunchtime staff directed people to listen to the music and commented on the songs.

Throughout the day staff sat and talked to people about their interests. Some people also took part in individual activities such as reading, colouring and word searches. A record was kept of what activity each person was offered each day, whether they engaged in the activity or chose not to. For example, it was observed one person was restless and they were asked if they wanted to look at look at some magazines with a staff member. This person asked to be left alone. Another person engaged with a staff member in a chat, looked at a magazine and then sang songs with this staff member.

Before people came to live at the service, the registered manager visited people and their relatives where possible to make a joint assessment as to whether the home could meet their needs. Assessments included aspects of people's health, social and personal care needs including their communication, mobility, nutrition, continence, skin care, and sleep patterns. This assessment was developed into a plan of care. Care plans contained guidance for staff about the support people required in relation to their health, social and personal care needs. For people who required assistance with mobilising, the number of staff and equipment required for each type of transfer was recorded. Daily notes recorded the support and personal assistance people were given each day.

People's care notes contained information about their past life, family, likes and dislikes. People were supported by staff, who were knowledgeable about people's choices, preferences and lifestyles. Care plans were reviewed monthly to help make sure they were accurate. A social care professional confirmed that

people's care plans, associated risk assessments and daily notes reflected people's needs

People and relatives knew how to raise a concern or complaint and felt comfortable doing so. They said they would talk to a member of staff or the registered manager, but that they had not needed to do so. One person told us, "I've not had to make a complaint but I know I could tell staff and they would listen". A relative told us, "I have not had a concern or complaint, but if I did I would talk to the manager or whoever was in charge on the day".

The service had a detailed complaints policy in place, which was available at the service. The policy informed people how to make a complaint and the timescales in which they could expect a response. There was also information and contact details for other organisations that people could complain to if they are unhappy with the outcome, including the Local Government Ombudsman, if people were not satisfied with the manner in which the service investigated their concerns. A complaints log was available to record how a complaint was investigated and that a response had been sent to the complainant in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

People and relatives/visitors said the service was well-led and that they were asked their views about the service. One person told us, "There are resident meetings each month. They ask me all sorts of things. About the food, what I would like to do and if I have any concerns or complaints". Another person told us "Since the new manager, the home as got better and there has been some decoration". Visitors/relatives all told us that there had been improvements in the service since the new registered manager had been in post. One visitor/relative said "They bend over backwards and I appreciate it. People couldn't live anywhere better". Another relative/visitor said "There have been a few mangers over the years and this one is the best". A social care professional told us that the registered manager and staff were "Excellent". They said there was good communication throughout the service and that staff always acted in a professional manner.

There was not an effective quality assurance process in place at the service. The provider regularly visited the service, as the registered manager was new to their role. Quality assurance audits and environmental and health and safety checks were kept up to date but there was no evidence that the findings of audits were acted on to improve the service. The registered manager had reported to the provider that the cupboard door of the controlled drugs cabinet required repair, but this had not been done.

The provider had not taken action to make improvements to the environment where shortfalls had been repeatedly identified for the last few months by the manager. The manager had submitted a report to the provider which identified that some carpets were worn and that redecoration was needed. The stairways, halls and doors looked worn and the hall carpet was stained and frayed posing a trip hazard. There was no budget for the maintaining the environment. Therefore the manager had to divert some funds from the petty cash budget in order for the lower floor of the building to be re-decorated. These areas were now light and airy.
A falls audit was completed monthly after reviewing accident and incident report forms but the effects of some of the falls were inconsistently reported to staff and the action taken to prevent repeats of the incidents, such as reviewing risk assessments, was unclear.

This lack of a fully effective and robust quality monitoring process was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager led by example and knew people well. She introduced the inspectors to all the people in the lounge, adjusting herself to their level, so she could more easily communicate. She knew each person and their personal preferences. For example, when speaking to one person she moved close to them so the person could hear what she was saying. This person affectionately stroked the registered manager's hair. When introducing another person she commented that they were, "cheeky". This person immediately responded in good humour and returned a "cheeky" comment!

Staff understood their roles and responsibilities and explained about planned developments in the service and how they contribute within their role. There was a clear understanding of management structure and team work and how this would bring about changes. For example, there was a plan to set up an old

fashioned sweet shop at the service. Staff were able to describe how these changes would make the service more personalised, in that activities would have greater structure and there would be more choice available to people to pick and choose what to do each day. Staff felt supported in the changes happening within the service. "The manager always listens to ideas I have", one staff member told us, "I feel that if we need to do something differently she listens and her door is always open".

People were actively involved in aspects of the service development, with quality assurance questionnaires provided in 'easy read' formats so they could provide their views. Meetings were held for people at which all attendees were asked their opinions and these were recorded. For example some people had requested having a shop in the service and the manager had agreed to try this with them in the near future. Feedback questionnaires were requested from relatives and other agencies with interest in the service. The registered manager had identified that there was a low response to these questionnaires and planned make these more prominent in the service to further encourage people to give their views.

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 did not take formal enforcement action at this stage. 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 Controlled medicines were not stored securely and there was not always guidance for staff about how to administer medicines prescribed as 'taken when required' (PRN) Regulation 12 (2) (g) Assessments of risk had not been identified or managed in relation to everyone's health needs or keeping people safe in the event of a fire. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not taken action in a timely manner to address identified risks in the environment. Regulation 15 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not effectively reviewed the service's audit and governance systems nor taken effective action where shortfalls had been identified.

Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not an effective staff training programme in place which ensured that staff received all the training essential to their role. Regulation 18 (2) (a)