Handsale Limited

Handsale Limited - Bierley Court

Inspection report

49A Bierley Lane
Bradford
West Yorkshire
BD4 6AD

Date of inspection visit:
17 May 2016

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08 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected the service on 17 May 2016. This was an unannounced inspection.

At our last inspection on 14 October 2014 we found no breaches of legal requirements. However, we asked the provider to make a number of improvements to the quality of care provided.

Handsale Limited - Bierley Court provides accommodation and personal care to a maximum of 40 people. On the day of our visit there were 38 people living at the home. Most of these people were older people and people living with dementia

The accommodation is arranged over two floors linked by a passenger lift. The home is divided into three units which include a general residential unit, an early stage dementia unit and an advanced dementia unit. All bedrooms are single rooms with en-suite toilet facilities. There are communal lounges and dining areas for people to use.

A registered manager was 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 told us the home provided them with a safe environment and raised no concerns about the way they were treated. Staff were aware of action they would take to keep people safe such as in the event of an emergency or if they were concerned someone was at risk of abuse.

Our observations, discussions with people and the layout of the building led us to conclude that although staff worked hard to try and meet people's needs, there were not sufficient numbers of care staff to ensure people were provided with consistently safe and effective care.

Care records were detailed, well organised and person centred. We saw that risks to people's health, safety and welfare were identified and action taken to reduce risk.

People told us the food was good and they were offered choices to ensure they had a varied diet. Nutritional risk was being assessed, monitored and managed.

Medicines were managed in a safe way. Records showed people received their medicines at the times they needed them and in line with the prescriber's instructions. Further improvements were needed to ensure decision making around covert medicines was clearly evidenced and regularly reviewed.

Staff received appropriate training, support and development so that they could provide safe and effective care. Robust recruitment checks were in place to ensure only staff who were suitable to work with

vulnerable people were employed.

Staff had a good understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 and their role in protecting the rights of people with limited mental capacity. Staff sought people's consent before they delivered care.

Where appropriate staff made referrals and worked with other health and social care professionals to ensure people maintained good health. Healthcare professionals told us care staff had worked hard to improve communication and ensure collaborative working.

Staff explained care and support to people so they could make informed decisions and understood potential risks in relation to their day to day care. Staff encouraged people to maintain their independence and respected people's privacy and dignity.

Staff knew people well and used this information to deliver personalised care. People and their relatives were involved in how their care was planned and delivered and their individual preferences and wishes were respected.

We saw staff worked hard to ensure people received appropriate interaction and stimulation that was appropriate to their needs, specific hobbies and interests.

A system of quality assurance was in place to ensure the provider and registered manager monitored the standard of care provided. We saw examples to show that these audits were effective in identifying areas for improvement and improving the quality of care provided.

The provider used a variety of methods to seek the views of people who used the service, such as care reviews, quality questionnaires and residents meetings. We saw evidence to show people's feedback was used to shape future development of the service and improve the quality of care provided.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found there was not always enough staff to provide people with consistent and effective care.

Medicines were managed in a safe way and were administered by competent staff. More robust care records were needed to evidence decision making where people received their medicines covertly.

Risks to people's health, safety and welfare were identified, monitored and managed.

People told us the home provided them with a safe environment. Staff understood safeguarding procedures and how they should report any suspicions of abuse.

Is the service effective?

Good

The service was effective.

People received a varied diet and nutritional risk was being assessed, monitored and managed.

Staff received appropriate support, training and development.

People were supported to maintain good health

The service was working in accordance with the requirements of the Mental Capacity Act which helped to make sure people's rights were protected and promoted.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and respected their privacy and dignity.

People were involved in making decisions about their day to day care and were encouraged to maintain their independence.

Staff knew people well and used this information to deliver personalised care.

Is the service responsive?

Good

The service was responsive.

People were involved in how their care was planned and delivered and procedures were in place to ensure complaints were investigated and learned from.

Care records provided staff with detailed information which enabled them to deliver personalised care and support to people.

People enjoyed a range of appropriate activities and trips out.

Is the service well-led?

Good

The service was well led.

A registered manager was in post and they promoted an open and honest culture.

A system of audits was in place to ensure the provider and registered manager monitored the standard of care provided. These audits were effective in identified areas for improvement and improving the quality of care provided.

People's feedback was sought and used to improve the quality of care provided.

Handsale Limited - Bierley Court

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.
The inspection took place on 17 May 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert-by-experience had experience of services for older people and people who lived with dementia.

Before the inspection, we reviewed the information we held about the provider such as notifications and any information people had shared with us. We also spoke with the local authority commissioning and safeguarding teams to ask them for their views on the service and whether they had any concerns. We reviewed the information on the 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.

During the inspection we spoke with 17 people who lived at the home, three relatives, five care workers, the cook, the manager and the provider. We looked at five people's care records, medication records and other records relating to the management of the home such as duty rotas, staff files, training records, maintenance records and service reports, surveys, audits and meeting notes.

We observed people being cared for and supported in the communal areas and observed the meal service at breakfast and lunch. We looked around the home at a selection of bedrooms, bathrooms, toilets and the communal rooms.

Following our inspection we spoke with two health and social care professionals about their experience of working with the home.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us the home provided them with a safe environment. One person told us, "I've nothing to worry about" and another person told us, "I have my own room key; it makes it very safe." However many people told us there were not always enough staff on duty. People told us they often had to wait for support because staff were busy. One person told us, "Staff try their level best but there is just not enough. The only thing I would improve is more staff, everything else is grand." Another person told us, "There's not enough staff. They come if I call them but sometimes it can be a while." This issue was also raised by the relatives we spoke with. One relative told us, "They do appear to be short staffed at times" and another told us, "They are short staffed, I come in everyday to make sure [my relative] gets fed if they are busy with other people." We saw a complaint being investigated at the time of the inspection suggested there had not been sufficient staff available to promptly respond to a recent incident.

We discussed minimum staffing levels with the registered manager. They told us shifts were usually 12 hours. One shift worked 8am to 8pm and the other shift worked 8pm to 8am. Each of the three units had one senior carer and one care assistant for each shift. The service also had two domestic staff, a chef, kitchen assistant, laundry and maintenance staff. The registered manager worked Monday to Friday. Four activities coordinators were also employed. Rotas showed at least two activities co-ordinators worked 10am to 3pm Monday to Friday. We saw the activities co-ordinators often supported care staff during busier periods such as lunch time. We were concerned this additional support was not available during evenings and weekends.

Staff told us they did not always feel there were enough staff. Some units had up to three people who required the support of two staff. Staff told us when they provided support to these people this left communal areas unattended. They told us they were most concerned about the dementia unit as people who lived there had the most complex needs. They also told us weekends and evenings were often challenging because activities coordinators were not around to provide support.

What staff told us was also reflected in the feedback we received from people who used the service. Many people told us they did not always receive support at the times they needed it because staff had to focus on providing care to people with more complex care needs, such as those who needed two staff to support them with personal care. One person said, "Staff are very busy but some people need more attention than me so I know I have to wait." Another person told us, "The staff are very busy, I have to wait sometimes but I know there are people who need more help than me, sometimes when the bells ring they have to go to other floors to help out." Whilst another person said, "I need help to get out of my chair, if they are dealing with someone else I have to wait. They are always having to help people like [person's name] and it takes two of them."

We saw a number of occasions where communal areas were left unattended for periods of up to 15 minutes because staff were providing support to people in their bedrooms. One person who lived on the dementia unit had a history of being aggressive towards other people who used the service. We were concerned the absence of a regular staff presence in communal areas risked that staff would not always be available to identify and respond to potential safeguarding incidents.

We saw examples where the absence of a consistent staff presence meant potential risks to people's health and wellbeing were not always identified and reduced. For example, on the dementia unit one staff member was on their break and another was providing support to a person in their bedroom. We saw two people began to look through the cutlery drawers in the dining area. One person took some napkins and cutlery from the drawer and put them in their pocket. Both people lived with advanced dementia and were not always able to identify potential risks and hazards. This was brought to the attention of a staff member to ensure both people were monitored whilst accessing these drawers to reduce the risk of injury.

We also saw staff were not always able to provide timely and appropriate support to people. For example, we heard one person calling for assistance from their bedroom. Their bedroom door was open and the person was sat in their chair. They pointed at their trousers which were visibly wet. They had been incontinent of urine and were visibly upset about this. They said, "I have been calling staff for ages but no one came. I have had an accident because I just couldn't wait any longer. I am so embarrassed. This isn't the first time." The inspector found a member of staff who then attended to their needs. Other people who used the service told us they often had to wait for assistance when they needed the toilet. One person said, "I often have to wait if I need the loo."

The registered manager showed us they used a dependency tool to calculate staffing levels. This was last completed in January 2016 and showed staffing numbers were 'above average.' The tool did not take into account all key issues, such as the layout of the building. Therefore whilst it was a useful guide it was not a comprehensive assessment.

Our observations, discussions with people and the layout of the building led us to conclude that although staff worked hard to try and meet people's needs, there were not sufficient numbers of care staff to ensure people were provided with consistently safe and effective care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the required checks had been completed before staff started work including a criminal records check with the Disclosure and Barring Service (DBS). This helped protect people from the risk of being cared for by staff who are unsuitable to work with vulnerable people. The registered manager told us they were renewing DBS checks for all staff as the local authority had highlighted it was good practice to do this every three years.

People's initial pre admission assessments identified potential areas of risk to people's health and wellbeing. This information was then used to develop risk assessments which identified risks and the control measures staff should take in order to mitigate the risk. These were reviewed monthly and amended and developed as people's needs changed and new areas of potential risk were identified. We saw people had risk assessments in place for areas such as manual handling, nutritional, falls, pressure sores and challenging behaviour. Other risk assessments were in place for specific risks. For example, records showed one person was at risk of spilling drinks. In their 'Maintaining a safe environment' care plan there was information to guide staff about how they should safely support this person with hot drinks to ensure the risk of injury was reduced. This showed staff adopted a person centred approach to managing risk.

Systems were in place to record and analyse accidents and incidents. Following an incident we saw action was taken to reduce the risk of similar events happening again. For example, a number of people identified as being at risk of falling had pressure matts in their bedrooms to alert staff when they were moving during the night. This enabled staff to go to their assistance quickly which helped to reduce the risk of further falls. The registered manager reviewed all accidents and incidents on a monthly basis to check for patterns or trends.

Safeguarding procedures were in place and staff demonstrated a good understanding of how to identify and act on any concerns. The provider had a safeguarding policy and information about how to raise a concern was displayed throughout the home for staff and visitors to refer to if needed. We saw previous safeguarding concerns had been investigated and action taken where appropriate. The information we hold about the service showed us the registered manager made referrals to other bodies where appropriate such as the local authority safeguarding unit and the Commission. We concluded that effective systems were in place to reduce the risk of abuse going unnoticed and investigate and respond to any concerns about people's welfare.

We found medicines were stored and administered safely. There were appropriate storage facilities including secure controlled drugs storage. Medicines administration records (MARs) were used to record when people were given their medicines. We checked a sample of completed MARs and medicines across two units. We saw the MARs were consistently completed with the dosage and time people had been given their medicines with no unexplained gaps. This meant there was a clear and complete record of the medicines and support staff had provided. The stock levels of all of the medicines we checked were correct.

We observed the administration of medicines on one unit. The senior carer had a good understanding of each person's medicines, knowing why they were prescribed and common side-effects. They knew which medicines had to be administered before and after food and potential risks. For example, they explained how one person was prescribed a medicine where the dosage changed depending on weekly blood clotting results. They described and showed us evidence of how they took appropriate action to ensure they gave the person the correct dose. We saw one occasion where the senior carer had not signed the MAR immediately after giving one person their medicine. They identified this error before it was brought to their attention by the Inspector. They explained their usual routine had been disrupted which caused the mistake. Our review of MARs and observations indicated this was not usual practice.

We previously asked the provider to look at the arrangements in place when people received their medicines covertly. During this inspection we saw some improvements had been made. However, further improvements were still needed to ensure care plans were robust and decision making around covert medicines was clearly evidenced and regularly reviewed.

We found the premises to be safely managed. There were appropriate facilities for people and the premises was well maintained and secure. Maintenance and checks of equipment were in place to help keep people safe, such as fire alarms, the lift, hoists and gas and electrical appliances.

Good

Is the service effective?

Our findings

People told us they were offered a choice of food and drink which was to their taste and preferences. One person told us, "The food is very good, I was a bag of bones when I came here and now I'm back to the right weight." Another person told us, "We get what we like to eat and a very good breakfast with fried egg, sausage and tomato." When asking one person about their lunchtime meal they told us, "We can have extra if we want."

We saw breakfast was a relaxed experience with no set time. This meant people could get up at a time of their choosing and enjoy their meal at their own pace. We saw people were offered a choice of hot and cold breakfast items. Where people found making a choice difficult we saw options were shown to them so they could make an informed decision. For lunch staff offered people a choice of jacket potatoes with various fillings or Gammon with vegetables. We sampled the food and found it was hot and flavoursome. We saw people were offered appropriate portions and the majority of people ate all their food. People were asked if they wanted second helpings once they had finished their meal. We observed some people had changed their mind about what they wanted to eat so staff promptly offered them an alternative meal. Outside of meal times we saw people were regularly offered drinks and snacks throughout the day. We saw staff encouraged people to drink additional fluids due to the warm weather. The chef had baked their "secret recipe" shortbread biscuits which were offered to people with their choice of drink during the afternoon.

Care records contained information about people's dietary needs and evidenced nutritional risk was being assessed and monitored. The chef was able to tell us which people had specialised diets and how they ensured these were met. Our review of records, observations and discussions with staff demonstrated that people's individual nutritional needs were being met. This led us to conclude that people received a varied diet and that nutritional risk was being effectively managed.

We saw evidence people were supported to maintain good health. Information on people's medical history and existing medical conditions were present within care plans to help staff be aware of people's healthcare needs. Care records provided evidence staff liaised with a range of health professionals to help ensure people's healthcare needs were met. This included district nurses, community matrons, occupational therapists, GP's and mental health services. Records showed staff made referrals to health professionals when they noted a change in people's needs or were concerned about someone's health. We saw evidence that communication between care staff and health professionals had improved. A new communications book had been introduced so that messages could be effectively passed on if care staff were not available when a health care professional visited. This was confirmed by a health care professional who told us, "Improvements have been made. We now have a good rapport with care staff. They follow our advice, keep us informed and work with us really well. I have no concerns."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us four people were subject to DoLS authorisations and all cases no conditions were attached. They told us a further 14 people required some restrictions to be in place to keep them safe and as such authorisations for DoLS had been submitted but they were still awaiting assessment by the supervisory body .

Staff had a clear understanding of the MCA and how to make sure people who did not have the mental capacity to make their own decisions had their legal rights protected. Care records clearly indicated when and how people should be supported to make decisions. For example, the protocols in place for 'as required' medicines indicated whether each person was able to make a decision about taking these medicines. Where people did not have the capacity to make this decision there was person centred information to help staff make a decision about whether it was in the person's best interest to administer this medicine, such as particular physical presentations which showed the person required pain relief.

We observed staff asked people for consent before providing support or care, explained what they were doing and obtained the person's agreement before continuing. This showed staff ensured people were in agreement before any care was delivered.

Effective systems were in place to support and develop staff. The registered manager maintained a training log which ensured staff training could be effectively monitored. The log showed the majority of staff were up to date with training in key areas. For example, the training log showed 100% of care staff had completed manual handling, 88% had completed safeguarding, 80% completed Deprivation of Liberty and 88% had completed a specialist course in dementia. We checked a sample of staff training certificates which showed the information on the training log was accurate. The registered manager had plans in place to ensure staff received training in all key areas throughout the coming year so that these percentages increased.

The people who used the service and their relatives did not raise any concerns regarding the skill level of care staff. Our discussions with staff demonstrated they were knowledgeable about key topics which showed that the training and developed they had received had been effective.

Records showed most staff received supervision every two months which included discussion of any concerns and future training and development plans. Records showed that supervisions were also used as an opportunity for the registered manager to assess staff's competency in key areas such as safeguarding and the MCA. This enabled any training shortfalls or areas for development to be identified and addressed.

Good

Is the service caring?

Our findings

When asked to describe the atmosphere in the home one person told us it was "Happy" and another person told us it was "Clean and friendly." People spoke positively about the attitude of care staff and said they were kind and respectful. One person told us "They are a grand set of women." One relative told us, "They are wonderful, they don't just look after [my relative] they look after me as well." Another relative told us, "I know [my relative] will be looked after if I don't come, I just come every day to be with them." Whilst people were positive about the overall standard of care provided many people told us that more care staff were needed.

During our observations we saw staff interactions with people were friendly and appropriate. Staff knew people well which was evidenced by them encouraging people to join in conversations about topics which were clearly of interest such as people's past lives, current news stories and the local community. Staff spoke confidently and provided accurate information when asked about specific details relating to people's care needs. We concluded that staff had a good knowledge of people's individual needs and preferences and used this information to deliver personalised care.

We saw staff encouraged people to maintain their independence. One person told us, "I'm encouraged to do as much as I can myself like washing myself. They are really trying to get me back on my feet." We saw staff offered choices and involved people in making decisions about their day to day care such as where and how they spent their time, what foods and drinks they ate and the level of support they received. For example, when supporting one person to the toilet staff asked them, "Which bathroom do you want to go too, the big one or your own?" People told us they felt in control of their daily routine. One person told us, "I can go to bed when I want, I normally get up early for breakfast but I don't have to." Being able to make such decisions enabled people to retain control over their lives and ensured people received support which was focused on their individual preferences.

We saw examples where staff explained care and support to people so the person could make informed decisions and understood potential risks. For example, we saw staff explaining to one person the importance of using their mobility aides to help reduce the risk of them falling and to another person about the importance of eating and drinking to help ensure they did not lose weight or become dehydrated. This showed us staff encouraged people to make decisions about how they wanted their day to day care to be delivered and ensured they were provided with enough information to make an informed decision. People's decisions were respected.

People told us staff respected their privacy and dignity. We observed staff knocking before entering people's bedrooms and heard a staff member say to a person who lived at the home and their relative, "I'll leave you alone to chat, let me know if you need anything." We saw a number of bedroom doors were left open when people were sat in their bedroom. People told us their bedroom doors were left open or closed in accordance with their wishes. Many people told us they had their own key which they used to lock their bedroom when they were not in it which made them feel safe.

People appeared comfortable, well dressed and clean which demonstrated staff took time to assist them with their personal care needs. One health care professional described how people were always clean and comfortable when they visited and people appeared to be well cared for.

Good

Is the service responsive?

Our findings

We saw people's needs were assessed before they moved in. This helped to make sure staff were able to meet their needs. This information was used to develop individual care plans and a 'service user profile' to show staff how each person should be supported to meet their needs. Care records also contained detailed information about people's individual preferences, likes, dislikes, hobbies, interests, family, friends, pets, holiday destinations and a life history. We saw staff used this information to engage with people in meaningful conversations and to deliver personalised care.

Care records were reviewed on a monthly basis which ensured the information contained within them was up to date and relevant. Where changes in people's needs occurred we saw that this was reflected within people's care records. People and/or their relatives had signed their own care plans which showed they had been consulted as part of the care planning process. Each person and/or their relatives also received a review of their care at least every six months. We saw this provided people with the opportunity to explain what was working well for them, identify areas for improvement and make suggestions to the way their care was delivered. People told us they found the care reviews useful and felt involved in the care planning process. One person told us, "It's nice to be asked and then to be listened to."

Information about how to make a complaint was available to people in the entrance to the home. Records showed there had been one formal complaint in the past 12 months. This was being investigated at the time of our inspection. The registered manager showed us how they were using the provider's complaints policy to guide them in responding to and investigating this complaint. They told us part of this process was to identify any lessons learned which would then be communicated to staff at team meetings.

The registered manager held monthly surgeries where people who used the service, staff and relatives could come and discuss any issues or concerns with them. These were advertised in the entrance of the home and in the quarterly newsletter. They said not many people attended these events but said they always operated an 'open door' policy but would continue to operate the surgeries to ensure they had this protected time.

People told us they felt able to approach staff if they had a concern and told us their first point of call would usually be their key worker. We saw people had the name and photograph of their key worker in their bedroom so that they could be easily identified. People were able to tell us who their key worker was and told us they liked having them as a point of contact.

We saw staff worked hard to ensure people received interaction and stimulation that was appropriate to their needs, specific hobbies and interests. One person told us, "I love baking and we do a lot of that, I am never bored, there is always something going on. I have more of a social life now." Other people told us they enjoyed the reminiscence activities and games and we saw some people living with dementia enjoyed caring for therapy dolls. People had access to the local community through attending social clubs and organised trips. One person told us they had enjoyed a recent trip out, they told us, "We went to the garden centre for a meal, I bought some plants for my room." On the day of our inspection we saw some people being supported to go to the local supermarket to do some shopping and other people went to the local

pub for lunch. People told us this was usual and something they enjoyed. We saw staff tried to monitor the activities people attended to identify, minimise and prevent isolation. We looked at some of the activities monitoring completed for one person who was at risk of social isolation. We saw that in the last two weeks they had attended eight one to one activity sessions and seven community events. People told us they had a choice about whether to participate in activities and there were regular coffee mornings where people decided what activities and trips they would like to arrange over the coming weeks. The local school raised funds for the home which the registered manager told us was used for trips and holidays. For example, last year some people had been supported to go to Flamborough Head for a long weekend. They told us they intended to arrange a similar trip this year but just for one night so more people could be encouraged to attend.

Good

Is the service well-led?

Our findings

The registered manager maintained a service improvement plan which identified the areas where they needed to focus on implementing change across areas such as policies and procedures, staff training, the environment and governance systems. The plan had an expected date of completion and assigned responsibilities to either the registered manager, deputy manager, provider or other specific staff members such as the maintenance coordinator. This enabled the registered manager and provider to monitor the progress of improvements, ensure responsibilities were fulfilled and provided oversight on the continuous improvement of the quality of care provided.

In addition, systems were in place to audit the quality and safety of the services provided and enabled the registered manager to identify for themselves other areas where improvements were needed. The audits we saw demonstrated a reflective approach to improving quality. We saw numerous examples whereby these checks had identified areas for improvement and where they had put plans in place to address them. For example, we saw a number of care plans which had been amended, improved and further developed as a result of the care plan audits completed by the registered manager.

The registered manager told us they felt supported by the provider. They told us the operations manager visited them approximately every six weeks. We saw that they now produced a report of their findings. We looked at their last visit from January 2016 and saw they had reviewed a range of areas with the registered manager including accidents and incidents, people's weights, staff training and recruitment. A company director for the provider also visited every quarter to perform a similar check. The provider also employed an external consultant to complete a full inspection of all aspects of care delivery and the home which mirrored the inspection's completed by the Commission. The first inspection had been completed in April 2016 and we saw the registered manager had an action plan in place to address their recommendations. This showed us that the provider had effective systems in place to assess and monitor the quality of the service provided.

We saw evidence that the registered manager and provider promoted an open and inclusive culture. The registered manager used staff meetings and supervisions to discuss lessons learned. For example, we saw the areas for improvement identified in the Commission's last inspection report had been discussed. We saw people who used the service were kept informed of key changes and improvements being made through monthly resident's meetings and a quarterly newsletter. The newsletter was a positive feature which helped relatives who were not able to visit frequently to keep in touch with what was happening in the home.

A notice board in the downstairs corridor was titled 'You said, we did.' The feedback which people had provided in the quality monitoring surveys completed in December 2015 was displayed, alongside information about what had been done to address the suggestions for improvement which had people made. Some of the actions which had been taken included purchasing new board games for the lounges and taking action to ensure that the car park was only being used by staff and visitors to the home. This showed us the provider and registered manager listed to and acted upon people's feedback and used it to improve the quality of care provided.

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 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) There were not always sufficient numbers of staff deployed to ensure people received consistent and appropriate care.