

# Barchester Healthcare Homes Limited

## Middletown Grange

### Inspection report

Middletown  
Hailey  
Witney  
Oxfordshire  
OX29 9UB

Tel: 01993700396  
Website: [www.barchester.com](http://www.barchester.com)






Date of inspection visit:  
10 February 2016

Date of publication:  
24 March 2016

### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Good</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

We inspected this service on 10 February 2016. This was an unannounced inspection. Middletown Grange Care home is registered to provide accommodation for up to 56 older people living with dementia who require personal care. At the time of the inspection there were 43 people living at the service.

We carried out an unannounced focused inspection of this service on 05 August 2015. We found a breach of a legal requirement. This breach was in relation to people not receiving activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred.

We found some improvements had been made at this inspection. People had access to activities and stimulation from staff in the home. However, these were not person centred. Activities were not always structured to people's interests. Relatives told us there wasn't always much to do. However, other people told us they were happy. We discussed these concerns with the registered manager, who informed us a new activity co-ordinator's post had been advertised, and staff were to receive coaching on dementia care and activities.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager worked closely with the area manager.

People who were supported by the service felt safe. The staff had a clear understanding on how to safeguard the people and protect their health and well-being. There were systems in place to manage safe administration and storage of medicines. There were enough suitably qualified and experienced staff to meet people needs.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care. Staff were quick to identify and alert other professionals when people's needs changed.

People received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People were supported to have their nutritional needs met and the dining experience was pleasant. However, the upstairs dining room looked overcrowded. People were given choices and received their meals

on time. We observed people during lunch time and saw people being supported with meals.

There was a calm, warm and friendly atmosphere at the service. Every member of staff we spoke with was motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way. Staff had also identified they needed more training in this area and the manager was arranging it.

People felt supported by competent staff. Staff benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they were caring for.

The manager informed us of all notifiable incidents. The service had good quality assurances in place. The manager had a plan to develop and improve the home. Staff spoke positively about the management and direction they had from the manager. The service had systems to enable people to provide feedback on the support they received.

Incidents and accidents were recorded by staff when they occurred. These included accidents to people, staff, relatives and visitors. However, there were no follow ups, outcomes or action plans made to prevent further occurrences. We discussed this with the manager and they were putting together a plan to manage incidents and accidents better.

We found two breaches 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 this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures and the service had an effective procedure in place to ensure people were safe.

Arrangements for medicines were in place to ensure they were administered safely and stored appropriately by staff

### Is the service effective?

Good ●

The service was effective.

Staff had the knowledge and skills to meet people's needs

Staff received training and support to enable them to meet people's needs.

People were supported to have their nutritional needs met.

People who were being deprived of their liberty were being cared for in the least restrictive way. Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to access healthcare support when needed

### Is the service caring?

Good ●

The service was caring.

People were supported by caring staff who treated them with dignity and respect.

Visitors to the service and visiting professionals spoke highly of the staff and the care delivered.

### Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People did not always receive activities or stimulation which met their needs or preferences.

People's care plans were current and reflected their needs.

Complaints and concerns were raised and managed with satisfactory outcomes.

### Is the service well-led?

The service was not always well led.

Changes in management had affected stability. However, the current leadership was good.

Incidents and accidents were recorded. However, there were no follow ups, outcomes or action plans.

Staff spoke positively about the team and the leadership. They described the manager and other senior staff as being supportive and approachable.

The leadership created a culture of openness that made people feel included and well supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

**Requires Improvement** 

# Middletown Grange

## 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.

This inspection took place on 10 February 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in dementia care.

Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from three healthcare professionals who regularly visited people living in the home. These professionals included a falls specialist, a care home support worker and social worker. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the manager, the regional clinical manager and eight staff which included nursing, care, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included five staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We spoke with five people and three relatives. We looked at seven people's care records including medicine administration records (MAR).

# Is the service safe?

## Our findings

People told us they felt safe and supported by staff. One person told us "I feel safe here. I have a panic button in case I need help". Another one said, "Care is safe and carers are pretty good in answering the call bell. Staff pop in to see me". Relatives told us, "He is safe, very safe, he had previous problems with falls and I would be informed straight away if there were any problems" and "She is very happy here, it's a lovely home. I have not seen anything to worry about".

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments were reviewed and updated promptly when people's needs changed. Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. Risk assessments included areas such as falls, using bed rails and moving and handling. Ways of reducing the risks to people had been documented and staff knew the action they would take to keep people safe. For example, one staff member told us "I make sure call bells and drinks are within reach. This is to prevent things like falling over whilst trying to reach for a drink or call bell". Some people had restricted mobility and information was provided to staff about how to support them when moving them around their home.

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding and whistleblowing procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us, "There is loads of training including safeguarding, moving and handling and use of chemicals".

People were supported by sufficient staff with the skills and knowledge to meet their individual needs. One nurse told us, "There is enough staff to ensure that residents receive appropriate care". The home used agency staff, however, they used the same staff and maintained consistency. One of the agency staff told us, "Systems are in place to promote safe care and enable agency staff to work with individuals safely. The care plans and medication records are very good and easy to follow". Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The service used a dependency assessment tool at the beginning of care provision as well as every three months to assess the need for staff adjustment. The manager considered sickness levels and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels.

Safe recruitment procedures were followed before staff were appointed to work at Middletown Grange home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Medicines were stored and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescription. Where people had limited capacity to make decisions about their own treatment, the provider had a detailed covert medicines policy which they followed. The policy stated how the covert medicines were to be given and that this was the most restrictive way. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why.

The environment was clean and tidy and maintained a homely feel. One relative told us the home was always very clean. Equipment used to support people's care, for example, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, checks were conducted by maintenance staff. We observed staff using equipment correctly to keep people safe. Staff were aware of the providers infection control policies and adhered to them.



# Is the service effective?

## Our findings

Staff were knowledgeable and skilled to effectively carry out their roles and responsibilities. One person commented on staff skills, "The new ones (staff) struggle a bit but on the whole staff are alright". One professional said, "Staff are very knowledgeable of the residents and are very proactive".

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. Staff comments included, "Induction was very good. It was followed by three weeks of shadowing" and "Induction was adequate and covered fire training and safeguarding".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. One member of staff said, "I asked for training in Parkinson's and I got it". Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and could identify any need for extra training.

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. Staff comments included, "We have unannounced supervisions and yearly appraisals where I can raise any concerns or need for more training", "We have supervisions every three months where the manager asks me how my role is going" and "During yearly appraisals we set targets for the following year". Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process.

People were supported to stay healthy and their care records described the support they needed. People had access to healthcare services and on-going healthcare support. Staff accompanied people to specialist appointments such as dentists and opticians. One person told us, "Staff get the doctor if I am unwell. Staff are very good and take me to my appointments in the minibus". Another person commented, "The GP came to see me when I was poorly".

Health and social care professionals were complimentary about the service and told us, "Staff are proactive. They have good referral systems and they follow through any professional advice we give them". They also told us staff promptly identified people's changing needs and involved other professionals quickly. People's care records showed details of professional visits with information on changes to treatment if required.

People told us they enjoyed their food. Comments included, "Food is very nice and always good", "I like the food here" and "Food is excellent with a really good choice and alternatives are available. I always have a drink". People were supported to have a meal of their choice by organised and attentive staff. Relatives

complimented on the quality of food. One relative told us the quality of food was "Pretty good". Another relative said, "Food is lovely and there is a great selection and choice of food".

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. The chef told us, "We get people's likes and dislikes completed forms and this allows us to give them what they like". They also told us they met with people regularly to discuss if they needed any changes in the food they were getting. The kitchen staff knew all the residents and had flexible menus. Some people had special dietary needs, and preferences. For example, people having diabetic diet, pureed food or thickened fluids where choking was a risk. Where some people had lost weight there was a plan in place to manage weight loss. The home contacted GP's, dieticians, speech and language therapists as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. We observed snacks were available for people throughout the day, such as fruit, cakes and biscuits. Staff were aware of how much fluid people needed on a daily basis and this amount was clearly recorded on each chart.

During lunch time we observed people having meals in both the dining rooms, upstairs and downstairs. In the downstairs dining room, the atmosphere was pleasant. There was conversation and chattering throughout the dining room. People chose where they wanted to sit and did not wait long for food to be served. There were a couple of empty tables. People were given choices, staff showed them two plates for each course of meal. People were supported to have a meal of their choice in a dignified way by attentive staff. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace. We saw people supported with meals in their rooms having the same pleasant dining experience as those in dining rooms. We saw staff asked people if they wanted more and this was provided as needed. However, in the upstairs dining room, it looked cramped making it difficult for people to access seats. We discussed this with the registered manager and they told us they were looking at opening a second dining room but in the meantime some people would be moved to the downstairs lounge for meals.

People's consent was sought before any care or support was given. We observed staff knocking on people's doors and seeking verbal consent whenever they offered care interventions. We also saw in care files that people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, all files reviewed showed consent for taking and using photographs. One person told us, "Staff ask permission to do any personal care".

Staff were aware of their responsibilities under the Mental Capacity Act 2005(MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions at a certain time. Records showed staff knowledge on MCA was often discussed during appraisals. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity, there was evidence of decisions being on their behalf by those that were legally authorised to do so and were in a person's best interests.

Staff had a good understanding of their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. People who lived under DoLS were being supported effectively and the DoLS were specific to the person's restriction. For example, people had DoLS for not leaving the home, decisions around health and decisions around resuscitation. Most people were under DoLS as they were not able to leave the home unsupervised and were under continuous supervision. Staff knew how to support these people in the least restrictive way.

# Is the service caring?

## Our findings

People were positive about the care they received. Comments included, "Very happy, there is laughter everywhere", "The nurses and most carers are very good" and "I just like being here. It's nice and cosy, visitors pop in and if you want anything they (staff) come". One person's relative told us, "I have not seen anything to worry about".

We observed many caring interactions between staff and the people they were supporting during our inspection. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and laughter throughout the day. One professional told us, "The staff are extremely caring and they know the residents". A relative commented, "I am so happy with the care and I have recommended the home to two other people".

Staff told us they enjoyed working at the service. Comments included, "I also work in other homes but I enjoy coming to this one. The staff work well together and are welcoming", "I love it here and love looking after people", "I enjoy my job. Everyday is different" and "The staff group is stable. Some people have worked here close to 10 years and this provides consistency".

Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted in a patient way offering choices and involving people in the decisions about their care. One member of staff said, "I look at it as if it's my mum being cared for". Another member of staff told us, "I looked after my mum and loved caring for them. I can care for the residents just the same". People were given options and the time to consider and choose. Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us how they treated people with dignity and respect. Comments include, "We shut doors and close windows during personal care", "Other people prefer female carers and we respect that" and "I am polite and talk to residents respectfully". One housekeeping staff member said, "When carers are in the room doing personal care, I wouldn't go in. I always check privacy and dignity is maintained at all times". One person told us she required two staff members to hoist her and that "they always maintain my dignity". People also commented, "I am treated with kindness and dignity. Staff respect my privacy by knocking on the door and waiting for me to answer before coming in to see me" and "They (staff) always knock on the door before coming in". One person's relative commented, "Staff care for my mother with privacy and dignity, for example, knocking on the door and closing it". Language used in care plans was respectful.

Staff understood and respected confidentiality. Comments included, "We do not talk to anyone about residents. It's confidential", "Don't discuss people's information with anyone else", "Care plans are kept locked in the nurses' station" and "If people phone up, we do not disclose personal information over the phone". We saw records were kept in locked offices only accessible using a keypad.

Staff told us that people were encouraged to be as independent as possible. One member of staff told us, "We give people opportunities to do things themselves". Records showed people's independence was promoted. For example, one person had limited mobility and at times needed help with moving from one place to another. Staff knew this person had good and bad days when they would be in pain and this affected their movement. The person's care plan noted staff to ask the person if they were in pain before supporting them. If the person was not in pain, staff encouraged them to do as much for themselves as they could. One member of staff told us, "We assist with meals but encourage the residents to do some themselves and maintain their independence".

People and relatives were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person had an advanced care plan (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they would maintain people's dignity and comfort and involve specialist nurses in the persons care. One member of staff said, "When a resident is end of life, we make them comfortable".

## Is the service responsive?

### Our findings

When we last inspected Middletown Grange in August 2015, we found people did not have meaningful activities throughout the home. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed the action plan sent following that inspection. We found some improvements had been made at this inspection. The provider had employed an activities coordinator who resigned five weeks before the inspection on 10 February 2016. Staff were on a rota to undertake activities with people on a daily basis. However, these were not person centred.

At our inspection on 10 February 2016 people and relatives told us there was not enough to do in the home. Comments included, "I hate the activities. They make me do things I used to do as a child", "There is not much to do. We do the same things again and again" and "There is a limit to what my mother can do but I do not see much going on". Records showed activities were not based on people's life history, social and family circumstances or preferences. There were no one to one activities recorded in care plans for people who stayed in their rooms. Relatives and residents meeting records showed activities were discussed as an issue in all the agendas in the previous months. The home did not have an activities coordinator.

We observed staff spend time with people throughout our inspection. In the dementia lounge a staff member was always present, however people went for periods of time without engagement from staff. One member of staff told us, "We need more activities that can engage people". We discussed these concerns with the manager who told us they were in the process of recruiting an activities coordinator. The manager told us they were going to oversee 'group' and one to one activities to ensure they were meaningful, stimulating and interactive for people. People's life histories, social circumstances and preferences were going to be used to form person centred activities. The manager assured us they were going to monitor and review daily records of activities in people's care plans.

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

People's needs were assessed prior to accessing the service to ensure their needs could be met. The manager personally visited people in their place of residence or hospital to perform the assessments. These assessments were used to create a person centred plan of care which included people's preferences, choices, needs, interests and rights. One member of staff told us they often accompanied the manager to do pre admission assessments. People and relatives also visited the home prior to start of care to make sure the home was suitable for them. One Relative told us they were, "Quite impressed with the staff. Made a few requests and they were met before my father arrived".

Care plans focused on people's personal history called 'memory lane communication'. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person preferred to stay in their room until after breakfast. We saw staff respecting this person's wish. This person told us, "I very rarely leave my room. I just like being here".

Care plans were reviewed monthly to reflect people's changing needs. Where need changes were identified, the plans were changed to reflect the person's needs. Records showed where appropriate, people and their relatives signed documents in care plans which showed they wished to be involved. Relatives told us they had been involved in developing care plans and reviewing care. One relative said, "I meet regularly with staff, we discuss and agree any changes in care".

Staff completed other records that supported the delivery of care. For example, food and fluid charts and charts to record how people's position was being changed to reduce the risk of pressure sores. These were up to date and there was a clear record of the staff input and care being carried out.

Feedback was sought from people through regular relatives and residents meetings as well as quality assurance surveys. Records showed that some of the discussions were around the provision of more activities and food choices. The chef told us menus had been changed to four weekly menu cycles following discussions during relatives and residents meetings. One relative commented that, "She meets with the manager now and again and has completed a questionnaire".

People and their relatives knew how to make a complaint and were confident action would be taken. The provider had a complaints policy in place. One person said that she "Sees the manager when they come round and would be able to get in touch if she had a complaint". Another one told us, "I know how to make a complaint if need be". One person's relative told us, "Previously raised concerns and they were dealt with quickly". Staff were clear about their responsibility and the action they would take if people made a complaint. Records showed complaints raised had been responded to sympathetically and followed up to ensure actions completed. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

## Is the service well-led?

### Our findings

Incidents and accidents were recorded by staff when they occurred. These included accidents to people, staff, relatives and visitors. However, there were no follow ups, outcomes or action plans made to prevent further occurrences. For example, there was an incident recorded involving two people living with dementia. The incident was only recorded in one of the care plans but not in the other care plan. There was no follow up or action plan done to avoid further incidences. We reviewed all the incidents recorded for the month of January and none of them had been followed up or had an action plan. This left people vulnerable and did not protect people's safety and welfare thereby putting them at risk of possible further harm. We discussed these concerns with the manager and they told us they were going to address this as a priority. The manager assured us they were going to hold clinical meetings every morning with the nurses and review accidents and incidents for the previous day.

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

People we spoke with knew the manager. Comments included, "Occasionally see the manager when they come round", "The manager pops in now and then. She is nice" and "I have seen the manager a few times".

Previously there had been several changes in leadership which affected management stability. One relative commented that there had been too many changes in management and "hoped that there would be consistence". At the time of our inspection, the manager had only been in post for two months. There had been significant changes seen since the manager's appointment. Staff comments included, "Manager is very supportive and approachable", "Aura around the home has improved since the manager came on to post. She is very professional" and "Very good manager. We have seen good changes in the short time he has been here". The manager told us they were looking at recruiting a deputy manager within the next month. Four members of staff were going to undertake care practitioner training starting in March 2016 and form a better management balance for the home.

Feedback received from health and social care professionals was complimentary about the service offered to people, their relationship with the manager and how well the management and staff team communicated with them. Comments included, "Very good communication", "Manager is very receptive" and "They have good referral systems. The manager is making good changes".

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. The provider had good quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, environmental safety, care plans and levels of residents need. The service used the Barchester observational tool 'Helping our homes get better'. These audits had identified areas of improvements across a number of areas of care.

The manager had an open door policy, was always visible around the home and regularly worked alongside

staff. People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. For example, residents and relatives meetings were held regularly and relatives could drop in anytime to speak with the manager. Relatives told us they attended relatives and resident meetings. One relative told us, "We have relatives and residents meetings. If I am not able to attend, I receive minutes from the meeting". People and their relatives met with the manager and completed questionnaires. One person's relative commented, "I have a meeting with the manager now and then and have completed a survey".

Staff described a culture that was open with good communication systems in place. Staff told us, "We have monthly staff meetings where we discuss about inspections, what needs improving and updates in the home", "We have good handovers every morning", "We have staff meetings and we receive minutes" and "We have monthly staff meetings". Records showed copies of staff meetings in staff files.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff said, "I know how to whistle-blow if I have to".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.



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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. Regulation 9 (1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of the people. Regulation 17 (2)(b).