Your Health Limited

Westwood House

Inspection report

35 Tamworth Road
Ashby De La Zouch
Leicestershire
LE65 2PW

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 7th December 2016.

The service provided personal care for up to 16 adults most of who were aged 65 years and over. At the time of our inspection there were 11 people using the service.

The service had a new manager who had commenced their role three months before our inspection visit. They were in the process of applying to become the registered manager for the service. 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 provider had systems in place for assessing the risks associated with people's care and reporting accidents and incidents. However, we found that staff did not use these systems correctly to ensure that they supported people to stay safe.

People did not always receive their medication as prescribed. We found concerns in relation to the administration of people's medicines. We also found concerns associated with temperatures that medicines were stored at. We also saw that some of people's liquid medicines were not labelled with the date of opening. This is important to ensure they are used within the recommended timescale.

Staff did not always have the skills and experience they required to carry out their role effectively. They told us that they did not always feel that the training they received equipped them to support people effectively. This included training to manage medicines safely and to complete people's records correctly.

People's records did not always reflect the support they received. This included not correctly reflecting their wishes about resuscitation towards the end of their life. This meant that there was a risk that people could be resuscitated and treated against their wish and best interest.

People were not always supported to engage in meaningful activities and to avoid social isolation. Staff told us that due to other work commitments the time the activities coordinator spent on activities was limited. At our last inspection at Westwood House, we saw that a person was supported to follow their interest in gardening and staff supported them to grow their own crops. At this inspection, we saw that they no longer continued with this activity. The manager told us that they would begin to make plans to engage and plan activities around people's interests.

People felt safe at the service. This was because staff understood what may constitute abuse and avoidable harm and their responsibility to safeguard people from harm.

There was a suitable number of staff on duty to meet people needs. Agency staff were used to cover any staff absences. People told us that staff responded promptly when they requested support from them. We found that the provider had safe recruitment practices which assured them that staff were safe to support people before they commenced their employment with the service.

The staff we spoke with demonstrated a varied understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's liberty was not deprived unlawfully. This was because the provider had made applications to the local authority for DoLS authorisation for people that required this. Staff supported people according to the conditions of the DoLS authorisation.

We received mixed responses about the food and the varieties that people were offered. We found there was limited variety at both lunch and tea time and the menus were repetitive. The provider was in the process of improving the menu.

People's feedback and records showed that they had regular support to access health care professionals. However, we saw that staff had not referred people to dementia outreach and falls managements services where they needed this support.

People complimented the caring attitudes of staff. They told us that staff treated them with dignity and respect, listened to them and supported them to be as independent as possible. Throughout the visit we observed that staff interacted with people in a warm and compassionate manner and supported people at their individual pace.

Staff supported people and their relatives to be involved in decisions about their care. People's family and friends could visit them without undue restrictions.

People and their relatives knew how to make a complaint about the care people received. We reviewed records of written complaints received at the service and saw that the manager put measures in place to address the issues that were raised.

During our inspection, we found that there were two significant incidents that the provider had not notified the Care Quality Commission of as required in law. People were not always confident that the service was well managed. They told us that they were getting used to having a new manager and hoped that they would make improvements to the service. Staff felt supported by the manager and deputy manager to fulfil their role. The provider had systems in place to monitor the quality of the service. However their audits did not identify the issues we found during our inspection.

We found breaches of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks assessments did not always reflect the current needs of people. Staff did not correctly use the provider's systems to record and report accidents and incidents at the service.

The administration and storage of medicines were not always safe.

There were sufficient numbers of staff on duty to meet people's needs in a timely manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The training staff received was not always effective. Staff did not always feel competent to meet people's needs in relation to managing their medicines and completing their records.

People's records did not always reflect their wishes about resuscitation towards the end of their life.

People were supported to access health services. However staff did not support them to access dementia and falls management services where this was required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always ensure that information about people was shared in a confidential manner.

Staff treated people with dignity and respect. They actively involved people in decisions about their care and support.

People were supported in a kind and compassionate manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to avoid social isolation. They were not always supported to follow their interests.

People's care plans were comprehensive; however, they did not always reflect their current needs.

People knew how to make a complaint. The manager dealt with their complaints satisfactorily.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had systems in place for monitoring and assessing the quality of the service. Their systems failed to identify the concerns we found at this inspection.

The Care Quality Commission had not been notified of some significant incidents at the service.

The manager and deputy manager were accessible to staff, relatives and people using the service.

Westwood 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.

We carried out our inspection visit on 7 December 2016. The inspection was unannounced. The inspection team consisted of an inspector, a nurse specialist advisor and an expert by experience (ExE). An ExE is a person who has personal experience of using this type of service or caring for someone who uses this type of service.

Before our inspection visit we reviewed information we held about the service. This included previous inspection reports and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law.

We spoke with three people who used the service, relatives of three other people, a care worker, an agency care worker, two senior care workers, the cook, the deputy manager and the manager. We looked at the care records of three people who used the service and people's medicine records. We also looked at staff training, recruitment and supervision records and the provider's quality assurance documentation. We observed staff and people's interactions and how staff supported people. From our observations we could determine how staff interacted with people who use the service, and how people responded to the interactions. This was so that we could understand people's experiences of care. Following our inspection, we received further documentation from the manager to support our evidence.

Requires Improvement

Is the service safe?

Our findings

Staff completed risks assessments where people were deemed to have areas of risk which may affect their support and wellbeing. This included risks of falls or maintaining their skin health. We saw that the risk assessments did not accurately represent the levels of risks associated with people's care. They also did not include measures in place to manage risks and maintain people's safety. Assessments were not always reviewed or when they were did not reflect the changes in people's needs. For example, a person's falls risks assessments identified them as having a low risk of falls despite their records detailing a number of factors which may have increased their risk of falls including a history of falls. We saw that following a hospital admission, which was triggered by a fall, staff did not review the support this person needed with mobilising. Staff had recorded that there were 'no new changes' to their mobility needs. We saw that this person had fallen again on the day of our visit and the previous day. This showed that risks assessments and measures to support people were not effective.

The provider had systems in place to record accidents and incidents. We saw that staff completed these records. However, they did not understand how to use the system effectively or analyse the information recorded. Staff told us that they had not been trained on how to use the recording system correctly. For example, we saw that they did not notify the Care Quality Commission or local authority of significant incidents and accidents or record any follow-up action they had taken. A person's records showed that the manager was not informed they had fallen because the person paid for their own care and 'did not have a social worker'. This showed that staff did not know how to use information of accidents and incidents to prevent future re-occurrences and to maintain people's safety. The manager told us that they would make arrangements to support staff with the recording of incidents and accidents and completing relevant follow up actions.

Staff took measures to store people's medicines safely following current guidelines. This included taking the daily temperature of medicines storage areas as temperature could impact on the shelf life and efficacy of medicines. We found that the temperature was above advised limits on at least three occasions within the previous three weeks. The deputy manager told us the issue had been identified during a medicines audit by the pharmacy supplier in September 2016. They said that they had informed the provider but was unsure of the action being taken to address the issue. We also saw that some people's liquid medicines were not labelled with the date of opening. This is important to ensure they are used within the recommended timescale and shelf life. The manager told us that they would follow this up.

People did not always receive their medicines as prescribed. We reviewed people's medicines administration record (MAR) and found there were several occasions where it was recorded by staff that people had not been given their regular medicines due to them being asleep. Some of these were medicines such as a medicine to reduce seizures. There were no records to show that staff ensured this person received their medicine as prescribed or that they had obtained further advice from the person's doctor. We also found an error in the dosage of medicine a person received to reduce blood clotting. We brought this to the attention of the manager who investigated the issue and found that staff had not followed appropriate medicines protocols. Following our inspection, the manager informed us that they had arranged for further

medicines management training for staff.

These issues constituted a breach of Regulation 12, (1) (2) (a) (b) (g) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

People felt safe at Westwood House. They told us that they felt safe because they found the service and environment homely. One person told us, "Yes. I feel at home and I feel safe. I'm quite contented. It's homely." Another person told us, "I do feel safe here. I've really settled and I'm really well looked after. I don't want to go anywhere else. I've got no complaints at all. They're all lovely whether it's the day or the night... They're really good." Relatives also felt that their loved ones were safe at the home. A relative told us, "Oh yes, very safe. [Person]'s happy and well looked after. They have no problems and no worries."

Staff we spoke with also told us that people were safe at the service. They told us that they checked people regularly. Staff told us that their mandatory training included safeguarding training where they learnt about how to deal with abuse and protect people from avoidable harm. They told us they would report any concerns to the manager and they would feel confident to use the provider's whistle blowing policy if necessary. Whistleblowing is when a member of staff notifies relevant authorities about poor care practice within an organisation. Staff told us that they would contact the Care Quality Commission (CQC) and the Local Authority Safeguarding team where necessary. A staff member told us that they had whistle blown when in a previous employment.

We saw that the equipment people required for their care was provided and was safe for their use. For example, pressure relieving mattresses and cushions were in place for people at high risk of developing skin injury and they were functioning correctly. Staff told us they had enough equipment to meet people's needs and when a piece of equipment became faulty it was checked by the maintenance department and repaired in a timely manner.

The provider had arrangements to respond to, and manage emergencies. People's care records included personal evacuation plans to guide staff on how to support them in the event of an emergency such as a fire.

There was a suitable number of staff on duty to meet people's needs. People told us that staff were available when they needed their support. One person told us, "I buzz and they [staff] come, – the staff are pretty quick." Other comments included, "I know they're really busy but you don't have to wait many minutes before they come." And, "Okay. Sometimes they get a bit busy but who doesn't?" Most of the relatives we spoke with agreed that there were enough staff to meet people's needs safely.

Staff told us that staffing numbers were sufficient for them to meet people's needs and preferences. They told us that agency staff were used to cover staff absences. They told us that there had been past occasions of staff shortage which had now improved. A staff member told us, "When we are fully staffed it's ok but when staff go off sick and we can't get agency it is a problem." Another said, "It used to happen regularly, but now it is rare."

The provider had safe recruitment practices. They completed relevant pre-employment checks before staff commenced their employment. These included a Disclosure and Barring Service (DBS) Check. A recently employed member of staff told us that following their interview the provider obtained references, and that they worked three 'shadow shifts' where they were observed before they were offered the role. These checks assured the provider that staff were safely suitable to work with people who used care services. An agency staff member on duty told us that their agency completed pre-employment checks before they were

deployed to work at Westwood.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the skills and experience they required to carry out their role effectively. They told us told us that they did not always feel that the training they received equipped them to support people effectively. Two members of staff whose role included administering medicines told us that they would like more training in medicines administration. They said the training they had completed was on-line and they would have liked the opportunity to attended face to face training where they were able to ask questions. They referred to training provided by the pharmacy earlier in the year; they stated that they had not found this very helpful. They told us they had fed this back to the manager at the time. Staff told us new care planning documentation had been introduced recently and they said it would be helpful to be provided with training. One staff member said, "They take a bit of getting used to." We found that these issues had adversely affected the care that people received as reported in the safe section of this report.

Staff told us they had not had supervision in the last 12 months and had not had an annual appraisal. Records confirmed that staff had not received recent support with supervision and appraisal. Supervision meetings are opportunities for staff to discuss any concerns they may have and receive feedback on their practice with their manager. A member of staff said, "Staff meetings have been few and far between." This meant that staff were not provided with opportunities to receive support and feedback in their role.

These issues constituted a breach of Regulation 18 (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

We saw that the provider assessed people's capacity to make their own decisions and that these were designed in accordance to the MCA and best interest decisions were made in people's best interest where required. However, we saw that these assessments and best interest decisions had not been recorded for all decisions such as using a sensor mat. We also found that staff did not accurately record in people's wishes about resuscitation in their care plan. Two people's care plans for their wishes towards the end of their life stated that they wished to be resuscitated. However, we saw other relevant documents that stated this was not the case. This meant that there was a risk that people could be resuscitated and treated against their wish and best interest. The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

The MCA 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had made applications to the local authority for DoLS authorisation for people that required this. Records showed that a condition of a person's DoLS authorisation which stated that they had a representative to support them in making decisions was met as stated. Staff had received training in MCA and DoLS. Staff we spoke with showed a varied understanding of MCA and DoLS and how they may apply them in their practice. Staff completed records to show that people had given their consent to the care and support they received.

A recently employed member of staff told us that they had completed the provider's mandatory training covering moving and handling, fire safety, health and safety, adult safeguarding, dementia, MCA, DoLS and first aid. They told us they were encouraged to ask if they were unsure about anything. They said, "If something could be done better, they [staff] will mention it to me." They also told us that they had received training in supporting people with behaviours that others may find challenging and found the training very helpful.

People told us that staff promptly supported them with health care visits when required. Their relatives agreed. One relative told us, "The GP always comes if [person] needs it. She sees the chiropodist." Another relative said, "We're taking [person] to the doctors to have her eyes done as she's diabetic. They [staff] deal with anything that happens immediately and we arrange the appointments." People's records showed that they had regular support from their doctor, chiropodist, and optician. Staff also referred people to other health professionals where required such as dieticians and psychiatry services. However, we saw that staff had not referred people to dementia outreach and falls managements services where they needed this support. The manager told us that they would include this in their plan of improvements to be made at the service. People's records included a personalised care plan with important information about the person in case of the need for a hospital admission.

We received mixed responses about the variety of food that people were offered. However, people told us that plans were in place to improve this. One person told us, "I enjoy it. They tell me what's on [the menu]..." Another person said, "[Food is] not good. Apparently they've got a [staff] who's sorting all the homes out and he's appalled at the food. He said it's got to alter but it won't happen overnight and may take a few weeks. I hope it's sorted before Christmas. It's supposed to be a four week rotation but you get cheese and potato pie and faggots twice a week. It's not varied enough." A relative told us, "[Manager] has sorted the menu for the better. There's more choice. Anything mum wants she can ask for. At the moment we're pleased with it...They have lager shandy!"

We checked the daily menus which staff told us was produced by the provider. There was a choice of three main meals at lunchtime but we found there was limited variety at both lunch and tea time and the menus were repetitive. We did not see any evidence of consultation with the people using the service in the development of the menus, or the information which had been collected about people's food preferences being taken into account. This meant that the provider had not taken into account people's preferences to meet their nutritional needs. The manager told us that they would continue to improve the way people's nutritional needs are met.

Requires Improvement

Is the service caring?

Our findings

We observed that people's information was not always treated confidentially. We saw that a senior member of staff held a telephone conversation regarding a person in the dining room whilst people were seated eating their lunch. The dining room was also used to hold staff meetings and other telephone conversations while people who used the service were using the room. This showed that people's private information was not always shared in a confidential manner.

People complimented the caring attitude of the staff that support them. They told us that staff were kind to them. One person told us, "They're all very nice." A relative told us, "[Staff are] Lovely. Very professional but also our friends." Another relative said, "They're lovely. Very friendly. They have a laugh."

Staff we spoke with demonstrated compassion and an interest in the people that used the service. A member of staff told us, "All the staff are amazing. They come in on their days off to see the residents and really care about them." Another member of staff said, "Staff are all caring. There's no one here for the wrong reasons." Throughout our visit, we observed that interactions between people and staff were warm and compassionate. Staff on duty communicated with people that used the service effectively and used different ways of enhancing that communication by touch, ensuring they were at eye level with people who were seated and altered the tone of their voice where needed. They reassured people where required and responded promptly, calmly and sensitively to requests for support.

Staff were knowledgeable about the needs and preferences of people they cared for. We listened to the shift handover and found relevant information about people's needs was handed over and checks arranged for all people who preferred to stay in their rooms. An agency staff told us that on their first shift at Westwood House, they were shown round the home by a member of staff and were introduced to all the people using the service. They said people's care needs were explained to them and they worked alongside an experienced carer.

We saw that there was a homely atmosphere at Westwood House. The lounge had plenty of personal items such as photos, birthday cards and belongings. It was decorated for Christmas with personalised homemade stockings on the fireplace for each person.

Where possible, staff encouraged people to be as independent as they chose to be. People told us that staff respected their choices and supported them to remain as independent as possible. One person told us, "I'm trying to be able to get up on my own. If you can't manage to do things they [staff] do help you but I know I do have to do it on my own if I can." Another person said, "Things I can do on my own they let me do them." People told us they were able to spend their time as they wished. One person told us, "I get up when I like and I go to bed as I like."

All of the people we spoke with responded positively when we asked them if staff treated them with dignity and respect. A relative responded, "If you said 1000% it wouldn't be enough. [Person]'s got back some of her dignity [since she moved here]." Staff were able to tell us the steps they took to promote people's privacy

and dignity, such as knocking on their bedroom doors, respecting their wishes and ensuring they were covered as much as possible when assisting them with their personal care. The home had six dignity champions. These are staff who support other staff to promote the delivery of care in a manner that protects people's dignity.

People and their relatives where necessary, were involved in planning their care. People's care plans included information which showed their involvement and agreement to the care and support plan. One person told us, "It [care plan] was reviewed a few weeks ago by the new manager – she did everyone's. [Manager] came in and my nephew was here." Staff told us they sat down with people and went through their care plans with them if they were able to understand. They said, "If the relatives are there, we involve them, and if things change we always talk with the relatives."

People's family and friends visited them without undue restrictions. We observed that relatives visited freely on the day of our visit. One person told us, "Yes. My nephew comes and takes me out. There are no restrictions that I know of." All the relatives we spoke with told us that staff made them feel welcome when they visited. A relative told us, "Yes. You can phone any time and visit any time."

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to engage in meaningful activities and to avoid social isolation. They told us that they were not supported to follow their interests. One person told us, "They haven't asked me [my interest] yet. I used to knit. I like doing my word searches but I didn't want to sit doing it in case the other ladies thought I was being ignorant." Another person told us, "Lambing – I used to like that. I potter about. I used to do gardening but we don't seem to do it now." At our last inspection at Westwood House, we saw that a person was supported to follow their interest in gardening and staff supported them to grow their own crops. At this inspection, we saw that they no longer continued with this activity. One member of staff reminisced on how much this person had enjoyed their gardening and the support they received to be able to do this. They said, "It's a shame. [Person] enjoyed that."

The provider employed an activities coordinator. Staff told us that the activities coordinator also worked in the kitchen and provided care so their time with activities was limited. They told us activities were mainly offered in the evening. They said the care staff often provided one to one activities in the afternoon such as foot massage or nail care. We asked people if the activities offered were suitable. Their responses included, "Occasionally, [staff] does activities in an afternoon. I don't join in by choice." Another person said, "I did some colouring for Christmas. I thought it would be good therapy for my hands. They said don't do too much in case it hurts your fingers. I joined in singing, it's the first time I've felt like singing for ages. I really enjoyed that colouring." A member of staff said, "It's a bit up and down with activities." The manager told us that they would begin to make plans to engage and plan activities around people's interests.

People's relatives told us that the needs of their loved ones were met at the home. They felt that staff understood and provided for people's individual needs. One relative told us, "Yes, it's the atmosphere. [Person] smiles and laughs. The staff are brilliant. We never felt she would be as she is now. It's down to the staff here and the care given…We can go home and be contented." Another relative commented, "If [person]'s been in hospital, they phone up to see what the situation is and to see if she's coming home. They wait here for her to get out of the taxi. If she is chesty, they will keep her in the lounge to keep an eye on her. The staff will stay with her. I don't ask them to but they do it."

People's care plans were comprehensive and included information about the level of support that people required for various aspects of daily living. They also included information about people's history, likes and preferences. This information help to support staff to provide support in a way that meet people's individual needs. However, we found the information in people's care plans was not always reflective of their current needs. For example, one person's care plan stated that they were hard of hearing and had hearing aids for both ears. We observed during our visit that the person was not wearing their hearing aids and staff were having difficulty in communicating with the person as they could not hear what was being said. We asked about the person's hearing aids and staff told us the person would not wear them and took them out. However, their care plan did not make reference to this and there was no evidence that staff had made any attempt to find out if there was a reason why the person refused to wear the aids and if there was a problem with them. Records showed that staff reviewed care plans however, they did not always update people's care plan when their needs changed. The manager told us that they would work with staff to improve

recording of people's needs in their care plan.

People and their relatives knew how to make a complaint if required. Most people told us that they would make a complaint to the manager or deputy manager. One relative told us, "I would see [deputy manager] first." Another relative said, "I'd see [deputy manager] or the manageress. I don't know her very well as she's only just started." A relative told us that a complaint that they had made was dealt with satisfactorily. They said, "Not a serious one, it's always dealt with." Staff told us that if a person wanted to make a complaint they would complete a complaints form and inform the manager. One staff member gave an example of a concern that had been raised by a relative and the steps that had been taken in response.

We reviewed records of written complaints received at the service and saw that the manager put measures in place to address the issues that was raised in the complaint. We received mixed responses when we asked people if they had opportunities to provide feedback about their experience of care. A relative told us that they had received questionnaires. They said, "Yes. I've filled loads of questionnaires in. I always have feedback on them." Other relatives told us that they had never received one.

Requires Improvement

Is the service well-led?

Our findings

The service had a new manager who had been in their role three months at the time of our inspection visit. They were in the process of applying to become the registered manager for the service. It is condition of registration that the service has a registered manager in order to provide regulated activities to people. The manager told us that their role included managing and sharing their time between two of the provider's homes. Following our visit, the manager informed us that they would now be based mainly at Westwood House to enable them to make the improvements that were required at the service.

The manager was supported in their role by a deputy manager. They were also supported within the organisation by a group quality manager and a compliance manager. The manager understood their responsibilities to report events such as accidents and incidents to the Care Quality Commission (CQC). However, we found that there were two significant incidents that we had not been notified of. We found that the deputy manager was not aware of the process of notifying CQC of significant incidents. The manager told us that they would support the deputy manager to be able to send notifications promptly.

People were not always confident that the service was well managed. They told us that they were getting used to having a new manager and hoped that they would make the required improvements to the service. One person told us, "I think it could be better managed but hopefully it will be now we've got a better manager." Another person said, "[Manager] seems alright. I can't speak 100% because she hasn't been here long enough. I had no complaints about [previous manager]." A relative told us, "[Manager] only just come. She seems as though she is [approachable]." Another relative said, "I haven't had to approach [manager]. I haven't had a conversation with her yet. Give her time and we'll see. She's not here all the while. She has changed the menus and done little trays with little biscuits and bits and bobs for the residents."

Relatives told us that they felt involved and were informed of any developments in the service. One relative told us, "They talk to us when we come in. We deal a lot with [deputy manager] but all the girls are approachable." Another relative said, "Yes, they let me know when I come to visit." Other comments included, "They [staff] tell us verbally when anything's happening, parties and things. They inform us and put the poster up."

Staff told us that they could easily approach the manager and deputy manager to seek support and guidance when needed. One staff member told us, "If ever there's a problem we all know we can speak to [deputy manager] or [manager]. Another staff member said, "We can always ring [manager] if she is not here. She is always contactable." A member of staff spoke of positive changes the new manager had made which had benefited people using the service. They said, "The changes [manager] has made since she has come here are amazing. She's absolutely brilliant." They talked about two people sharing a room and the way the furniture had been re-arranged to provide them with more privacy. They said, "She is all for the residents."

The provider had systems and procedures in place for assessing and monitoring the quality of care they provided. These included quality assurance audits of people's care and support records and the general maintenance of the building and equipment. We found the audits did not identify the issues we found such

as those in relation to medicines management, risks assessments and staff training. At the time of the inspection the manager was unable to locate the medicines audit carried out by the external pharmacy prior to their appointment in September. They were unaware of the issue with the temperature of the medicines room until we raised it with them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care was not accurately assessed and recorded. The provider did not take all necessary steps to mitigate risks and reduce the reoccurrence of accidents. People's medicines were not always stored safely and measures were not in place to address this issue. People did not always receive their medicines are prescribed by their doctor.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive training and supervision that supported to carry out their role effectively.