Eastlands Health Care Limited

Eastlands

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 8 September 2016. Eastlands is registered to accommodate up to 20 people at the home who require nursing or personal care and treatment of disease, disorder or injury. At the time of the inspection there were 16 people using the service.

On the day of our inspection there was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection an application to be registered as the manager had been made by the person managing the home. We will monitor the progress of this application.

People were supported by staff who could identify the potential signs of abuse and knew who to report any concerns to. Risks to people's safety were assessed and reviewed, although the frequency of these reviews was inconsistent. There were enough staff to keep people safe.

People's medicines were not always managed safely. Processes for the timely ordering of people's medicines were not effective. There were also discrepancies in the stock levels of some medicines and people's medicine administration records were not always appropriately completed. Guidance for the administration of 'as needed' medicines was in place, although a review of the administration of these medicines was needed to ensure they were administered appropriately.

People were supported by staff who completed an induction prior to commencing their role and had the skills and training in place to carry out their role effectively. Not all staff received regular supervision of their work and an effective appraisal system was not yet in place.

The principles of the Mental Capacity Act (2005) had not always been followed when decisions were made about people's care. Some assessments were comprehensively completed, whereas others were too generic and increased the risk of decisions being made for people that were not in their best interest. Applications to the authorising body to legally deprive people of their liberty had been made for the people who had been assessed as most at risk; however, further applications for others within the home were required.

Staff communicated effectively with people. People received a varied diet that took into account their food and drink preferences. People's day to day health needs were met by staff and external professionals where required.

Staff treated people with respect and dignity and listened to and acted upon their views. Staff respected people's privacy and people were involved with decisions made about their care. People were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates, although this information was not easily accessible. People's friends and

relatives were able to visit whenever they wanted to.

Whilst some people received support in following the hobbies and activities that were important to them, others did not. People's support records were person centred and focused on providing them with care and support in the way in which they wanted. People were provided with the information they needed if they wished to make a complaint, however the format in which the complaints process was written, could make it difficult for people with communication needs to understand.

The manager acknowledged that improvements were required to ensure that people received a high quality of care and support at the home. Although relatively new to their role, the manager had plans in place to address these issues. The manager held regular discussions with representatives of the provider to discuss and agree how to make these improvements.

The manager was visible throughout the inspection. Staff and the people who lived at the home spoke highly of them. The manager, although not yet registered with the CQC understood what was required of them once they became registered. Quality assurance processes were already in place to address the areas of concern identified within this report. People were encouraged to provide feedback about the quality of the service and this information was used to make improvements.

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

People's medicines were not always managed safely or appropriately.

People were supported by staff who could identify the potential signs of abuse and knew who to report any concerns to.

Risks to people's safety were assessed and reviewed, although the frequency of these reviews was inconsistent.

There were enough staff to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act (2005) had not always been followed when decisions were made about people's care. Further applications to legally deprive people of their liberty were required.

Not all staff received regular supervision of their work and an effective appraisal system was not yet in place.

People were supported by staff who completed an induction prior to commencing their role and had the skills and training in place to carry out their role effectively. Staff communicated effectively with people.

People received a varied diet that took into account their food and drink preferences. People's day to day health needs were met by staff and external professionals where required.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity and listened to and acted upon their views.

Staff respected people's privacy and people were involved with decisions made about their care. People were encouraged to lead as independent a life as possible.

People were provided with information about how they could access independent advocates, although this information was not easily accessible.

People's friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Whilst some people received support in following the hobbies and activities that were important to them, others did not.

People's support records were person centred and focused on providing them with care and support in the way in which they wanted.

People were provided with the information they needed if they wished to make a complaint, however the format in which the complaints process was written, could make it difficult for people with communication needs to understand.

Is the service well-led?

Good

The service was well-led.

The manager was new to their role and had plans in place to make the improvements identified within this report. The manager held regular discussions with representatives of the provider to discuss and agree how to make these improvements.

The manager was visible throughout the inspection and staff and people who lived at the home spoke highly of them.

People were encouraged to provide feedback about the quality of the service and this information was used to make improvements.

The manager, although not yet registered with the CQC understood what was required of them once they became registered.

Eastlands

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 8 September 2016 and was unannounced.

The inspection team consisted of one inspector and specialist advisor (nurse).

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided.

We spoke with four people who used the service, one relative, three members of the care staff, the cook, two nurses, one of the activities coordinators, the administrator, manager and operations manager.

We looked at the support records of four people who used the service. We also reviewed parts of other records for other people living at the home. We viewed a range of records relating to the running of the service, this included policies and procedures and auditing documentation. We also reviewed staff records.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with did not raise any concerns with us regarding the processes that were in place to manage their medicines. We observed a staff member administer people's medicines which they did in a safe way. However, we were told by the member of staff that one medicine had not been given to a person on the morning of the inspection as it had not been available; however we noted in the person's records that it stated it had been given. We discussed this with the staff member and they told us they had made an error in the recording and they then amended the person's medicine administration records (MAR).

We found other areas of concern in relation to recording when people had received the medicines. We found gaps in other people's records, which could suggest that people had not received their medicines. However, when we checked the stock levels for these people, we found they were correct. Inconsistent recording of when people had received their medicines could increase the risk of people receiving too much or little, which could have a serious impact on their health and welfare.

Medicines which been handwritten on people's MAR had mostly been signed by two people to ensure accuracy of transcription. This reduces the risk of errors being made in relation to the amounts and frequencies a person should receive their medicines. However, we found one set of medicines which had only been signed by one person.

The process for ensuring the timely ordering of people's medicines was not adequate. We found a number of examples where the stocks of medicines in place for some people were not sufficient to last them until the next order was made. This meant there was a higher risk of people not receiving their medicines when they needed them, which could have an impact on their health.

We raised this issue with the manager. They told us they were aware of the concerns in relation to the timely ordering of people's medicines and had implemented a new auditing process to enable them to identify potential stock issues and to deal with them before they impacted on people. They also told us they were in regular discussion with their medicines provider to assist them with improving the process for the ordering of medicines.

Protocols were in place to provide the additional information required about medicines which were prescribed to be given only as needed, rather than routinely, and these were well completed with a good level of detail. For example, we saw a clear protocol was in place detailing when medication was required for a person who had frequent epileptic seizures.

However, we also identified examples where these processes were not always followed effectively. Records showed one person had been prescribed a medicine to be given only as required, yet the person's MAR showed they were given routinely and daily. If the person required this medicine daily, a request to review the medicine should have been made to the GP. We raised this issue with the manager who advised they would contact the person's GP to request a review of the person's medication.

Medicines were stored securely in locked cupboards, and trolleys within locked rooms but the refrigerators used to store medicines were not locked. The lock on the refrigerator on the upper floor was broken, which could increase the risk of people accessing medicines that could cause them harm. We were told by the manager that this had been reported to the pharmacy supplier and they were waiting for this to be repaired.

These were examples of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

The temperature of the rooms and refrigerators used to store medicines were recorded daily and were within acceptable limits. This ensured the effectiveness of the medicines was not affected by too high or too low storage temperatures.

People told us they felt safe living at the home. One person said, "I do feel safe; staff look after me very well." Another person said, "They are all kind and good to me." A relative said, "[My family member] is safe here. It is so much nicer than the homes they have been to before."

People were supported by staff who understood the types of abuse people could face at the home. They knew the procedure for reporting concerns both internally and to external bodies such as the CQC, the local multi-agency safeguarding hub or the police. A staff member said, "I would report things to the nurse in charge. I'd also report to the manager and area manager if I needed to. If I wasn't happy with the action taken I'd contact the CQC, or worst case scenario, the police."

Records showed a safeguarding adults policy was in place and that staff had received safeguarding of adults training, which ensured their knowledge met current best practice guidelines.

Processes were in place to support people with managing their finances and to protect them from the risks of financial abuse. People told us they had a small amount of cash which staff kept in the safe for them and when they needed money it was signed in and out. Two people told us they had their own bank card to use. We checked the amounts of money stored for four people who used the service to ensure they matched the amounts recorded in their records. All four amounts were correct.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. Regular servicing of equipment such as hoists and walking aids, gas installations and fire safety and prevention equipment were carried out, and we saw these had been conducted within the last year. External contractors were used to carry out work that required a trained professional.

Individual risk assessments had been completed for people to reduce the risks in relation to nutrition, falls, development of pressure ulcers, moving and handling and the use of bed rails to prevent people falling out of bed. We noted there was an irregular approach to the reviewing of these records. We saw some records had been reviewed monthly whereas others had not. For example we saw an assessment for a person who was at risk of falls had not been updated for four months. Irregular review of people's care and support needs could increase the risk to their health and safety.

People had individualised personal emergency evacuation plans (PEEPs) in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. These plans took into account people's physical and mental ability and were regularly reviewed.

Reviews of the accidents and incidents that occurred at the home were carried out regularly to enable the manager to identify whether there were any common factors that contributed to them. The manager told us

this analysis enabled them to put preventative measures in place to reduce the risk of reoccurrence.

Throughout the inspection we saw there were enough staff to meet people's needs. We observed staff respond quickly when people needed their support. A relative said, "There are always staff around." We received mixed feedback from staff with regards to the number of staff working at the home. Most staff felt that when they had a full staffing team there were enough staff to support people safely. However, some staff also raised concerns that when people phoned in sick at short notice that this sometimes had an impact on their ability to carry out their role.

The manager carried out regular reviews of people's level of dependency and told us this enabled them to put in place the appropriate number of staff where required. Due to a recent high turnover of staff, this has on occasions led the use of agency staff to cover shifts. The manager told us they requested the same staff each time to ensure that people received consistent care from the staff supporting them.

We asked the manager how they ensured the agency staff members were aware of the risks at the service when they first came to the home. They told us they would complete a brief induction which would include being able to identify where the fire exits were in case of an emergency. When we asked to see copies of these documents that had been completed for each agency staff member, the registered manager was unable to show us any examples. This meant we could not be certain that these staff had completed this induction, which could have an impact on the safety of the people they were supporting.

The risk of people receiving support from staff who were unsuitable for their role was reduced because the provider had ensured that appropriate checks of a staff member's suitability for the role had been carried out. Records showed that before staff were employed, criminal record checks were conducted. Once the results of the checks had been received and staff were cleared to work, they could then commence their role. Other checks were conducted such as ensuring people had a sufficient number of references and proof of identity. These checks assisted the provider with making safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with told us they had confidence in the skills and knowledge of the permanent staff. One person told us it had taken them a while to trust people and staff had spent time getting to know them and their needs. However, there were also concerns raised that when agency staff were used they did not always know and understand people's needs. One person said, "They don't know me well enough."

The manager told us that all training was up to date, or if refresher courses were needed these had been booked. They also told us that all staff carried out a formal induction prior to commencing work. Records viewed supported this.

Staff told us they felt well trained; however they did raise concerns that they did not receive regular supervision of appraisal of their work. One staff member said, "I have not had supervision for quite a while now. This is mainly due to staff turnover. It is a problem." Another staff member said, "I feel well trained, although supervisions rarely happen. I should have them every two months, but it doesn't happen."

Records showed there was an inconsistent approach to carrying out supervision of the work carried out by staff. We saw some staff had received two or three supervisions in the past nine months, whereas others had received one or in some cases none. Regular supervisions are important to ensure that staff performance can be reviewed and monitored and any areas for improvement can be identified to reduce the possibility of poor or inappropriate care being provided for people. The manager told us it was company policy for staff to receive supervision approximately every two months, but acknowledged that this had not always been completed. They told us the recruitment of a new deputy manager will rectify this as managing this process will be their responsibility.

We also noted that staff appraisals, used to assess staff performance for the previous working year had not been carried out for all staff. The manager told us they were aware of the need to ensure these were carried out and would address this immediately.

People's care records contained detailed guidance for staff to enable them to communicate effectively with people. Throughout the inspections we saw staff use a variety of skills and different methods to communicate with people who were living with dementia. People responded positively to the way staff communicated with them.

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

In each person's records we saw there was an inconsistent approach to the process for assessing whether a person had the ability to make decisions for themselves. In one support record we saw detailed assessments

had been carried out on their ability to manage their own medicines, finances and to provide themselves with adequate levels of personal care. However, in three other records we noted that although each person had been assessed as being unable to make decisions, the assessments and subsequent decisions made for them were too wide reaching and not specific. For example the assessment in one person's records stated; 'Consent to care and treatment as detailed in care profile'. This did not indicate which decisions the person could and could not make and therefore increased the risk of decisions being made for them that were not in their best interest.

People can only be deprived of their liberty to 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 are called the Deprivation of Liberty Safeguards (DoLS). Records showed that DoLS applications had been made for people who had been assessed as being most at risk if they accessed the community alone. We looked at the paperwork for two of these people and saw the staff adhered to the terms recorded. However, having discussed the needs of each person living at the home with the manager, it was clear that applications may be needed for all of the people living at the home. The manager told us they would review each person's needs and make the required application to the authorising body.

We recommend that the provider reviews its processes for assessing people's ability to make decisions about their care, and ensures the principles of Mental Capacity Act 2005 are always followed appropriately.

Records also showed that all staff had received MCA and DoLS training, although a small number required refresher training. The staff we spoke with had a good understanding of the MCA and knew how to implement it effectively into their role. A staff member said, "I give people choices; clothes, food etc. I help them to make decisions as much as I can."

When people expressed themselves using behaviours which others may find challenging, a support plan was in place to provide information about the behaviour, the action for staff to prevent the behaviour escalating and the best way for them to respond. There were details of each type of behaviour and activities they could use to distract the person or how to respond effectively.

People told us they enjoyed the food provided for them at the home. People told us they were offered a choice and if they did not want what was offered, they felt they could ask for something different. One person said, "They always ask me if I want anything else so I always have enough to eat."

We observed the lunchtime meal in two of the dining rooms. People were asked how much food they wanted and staff checked whether they wanted any assistance with eating. If they did, staff sat alongside people and provided them with the assistance required. When staff supported people, they engaged in conversation with them and did not become distracted, ensuring the person received their meals uninterrupted. Some people chose to eat in their rooms and they were served in a timely manner.

We spoke with the cook who showed us the four week rotated menu that was provided for people. The menu was varied and nutritious. Records showed people had recently attended a food forum where they were asked for their opinions on the food provided; used to inform the cook of the food people liked and disliked. The cook had detailed dietary information for each person who used the service. This included information about allergies and food intolerances, food likes and dislikes, preparation of food (e.g. soft or pureed diet) and any assistance they required with eating and drinking.

Nutritional risk assessments had been completed and care plans were in place for eating and drinking. We saw people had been weighed monthly and the records we reviewed showed people were gaining or

maintaining their weight. Records of fluid intake were documented and we saw people were receiving an adequate fluid intake. When people were receiving enteral nutrition, the delivery of part or all of the daily requirements by use of a tube; the volumes, and start and stop times were recorded. This ensured that staff were aware of the amount each person received via the tubes.

People's day to day health needs were met by staff. People's support records and observational charts showed that where risks had been identified staff had provided support in line with the guidance provided by external professionals. People's support records contained evidence of the input of a range of professionals including their GP, dietician and continence service. Some people were seeing a physiotherapist regularly.

Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly and set appropriately. Many people had specialised seating and wheelchairs with support for the head and limbs as necessary. A person told us their wheelchair had been checked when they came to the home and would be checked regularly by maintenance staff.

A relative we spoke with told us they were pleased with the way their family member's health was monitored. They said, "[My family member] is really well looked after here."

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring. One person said, "The regular staff are absolutely lovely and some of them really understand you." However, they went on to say some of the agency staff who sometimes worked at the home, "Don't seem caring." Another person said, "The staff really seem to care." A relative, when comparing Eastlands to other homes their family had lived at said, "[My family member], is treated like a person here."

We observed staff interact with people throughout the inspection and we saw some very positive interactions. For example, we saw a staff member encourage a person who had mobility needs, attempt to walk along a corridor rather than use their wheelchair. The staff member was encouraging, supportive and reassuring and the person responded positively to them. Once they had walked a few steps, they sat back in their wheelchair with a smile on their face. We saw other examples where people were supported to be as independent as they wanted to be. For example, people were encouraged to eat independently if they were able to and people were supported to access other parts of the home if they wished to.

People's support records contained detailed information about what was important to them and also included information about their life history. We saw staff use that information to form meaningful relationships with them. Light hearted banter along with conversations about people's support needs were commonplace. We observed staff sitting and talking with people. They showed a genuine interest in what people had to say and people responded positively to them.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life.

People told us they felt involved with decisions about the care and support needs. They told us they were always given choices. One person said, "They ask me if I want a shower or a wash, they give me choices at mealtimes and they never make me do anything I don't want to do." Another person said, "We have a risk assessment and as long as we are aware of what could happen we can do it. I have never been told no." People told us their support plans were regularly discussed with them and they felt involved. One person said they had signed their support plans and we saw evidence of this in their and others' support records.

Information was available for people about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. Information for other health and social care services was also available to assist people if they wished to discuss their financial affairs or health related matters. However, we noted that some of this information was located in the reception area of the home, which was behind a locked door. This could make accessing this information difficult for some people. The manager told us they would address this by ensuring this information was made more readily available within the living space of the home.

People told us they felt staff protected their privacy and dignity when providing care, by shutting their bedroom door, closing the curtains and keeping them covered as much as possible. They said they had been asked if they had a preference for female or male staff and staff adhered to this. One person said, "Privacy is a big thing for them here, they are really hot on it."

There was plenty of space available throughout the home if people wished to have time alone or time with visiting family and friends. We observed staff respect people's privacy and when people asked to be alone, staff respected their wishes.

We observed staff treat people with dignity and respect throughout the inspection. This included during conversations between staff when speaking about people's care and support needs. However we did observe staff supporting one person with a procedure in a public area which could have impacted on the person's dignity and right to privacy. However, the staff who were supporting the person were encouraging and offered reassurance throughout.

People's care records were handled respectfully. Records were returned to the office where they stored as soon as staff had finished using them. This ensured that people's personal records could not be viewed by others, ensuring their privacy was maintained.

The manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. A person who used the service said, "There are no opening times, they can come as and when they like." We observed relatives visiting people throughout the day.

Requires Improvement

Is the service responsive?

Our findings

A person we spoke with told us they felt able to take part in the activities that were important to them. They told us they had the opportunity to do things in the local community such as go to the cinema or the local pub. They said they could spend time in the lounge or in their room and they had a laptop. They said they had completed a college course and had obtained their functional skills award. Another person told us they liked to go out into the garden and we observed a staff member support them with doing so.

There were two activities coordinators employed at the home. However, during the inspection we noted very little activities taking place. Some of the staff we spoke with expressed concerns that the activities provided were limited and when they were provided, they were not always appropriate for some people living with more complex needs. During the inspection we did not see any activities taking place, despite there being two activities coordinators working on the day.

We also noted in people's support records there was very limited recorded examples of people being offered activities in line with their interests. We did see one person enjoyed having their nails painted and this was offered; however, this was a rare recorded example of people being able to do the things they wanted to do.

We raised these concerns with the manager and the operations manager. The operations manager told us they also had concerns with the effectiveness of the activities provided at the home and assured us that they were going to implement changes at the home, to ensure that all people were given more opportunity to follow their interests.

Initial assessments of people's care and support needs had been completed when they were admitted to the service, and there was a helpful summary of their needs to provide guidance to staff along with a record of their preferences in relation to the activities of daily living.

A range of support plans were in place for each person detailing their care and support needs. These contained information about each person's preferences and wishes in relation to their care. Support plans, in place to support people with health conditions were comprehensive and indicated people had had access to specialist input and advice as necessary. Support plans had not always been reviewed regularly although we did not find any evidence of care plans which were not reflective of people's current needs.

We saw examples were measures had been put in place to support people with complex needs. For example, a person who could not use a call bell told us a monitor had been put in their room so they could shout for assistance if they needed it and a member of staff would come. However, they also said staff normally checked on them regularly ensuring they were safe.

People told us if they rang their bell a member of staff responded fairly quickly. One person said, "When you press the buzzer, you have to wait a bit but not long."

We saw records were completed for people who required regular input with their care and support needs.

This included people who required regular repositioning to reduce the risk of developing a pressure sore, records of regular urinary catheter changes and checks on people who required tracheostomy care. A tracheostomy is an incision in a person's windpipe, made to relieve an obstruction to breathing.

When we spoke with staff they had a good understanding of people's care needs. They could explain how people liked to be cared for and supported, and our observations throughout confirmed that staff ensured people were directly involved with the decisions about their own care.

People were provided with a service user guide which explained the type of service they should expect to receive when they came to the home. Also within the service user guide was a complaints policy. The policy contained details of who people could make a complaint to outside of the home if they wished to. This included the CQC and local authority. We noted the complaints process was not available in an easy read format, which could make it difficult for people with communication needs to understand. The manager told us they would review the process and amend it to make it easier for people to understand.

People told us they were happy with the way their complaints had been handled by the staff. The staff we spoke with were able to explain how they would support a person who had made a complaint to them.

We viewed the complaints register and saw the manager had ensured that when a complaint had been made this was dealt with quickly and people were responded to in a timely manner, in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

The manager of the home told us they had been in post since April 2016. They acknowledged that there were areas for improvement within the home, as described in this report. They showed us the plans they had in place, which had been discussed and agreed with the operations manager, on how to make these improvements.

Records showed a variety of processes were now in place in order for the manager to regularly review the quality of the care and support provided for people at the home. These included; weekly head of department meetings to discuss any concerns the nurses, cook, maintenance person and senior carers had with their respective areas. Additionally monthly management audits were carried out to identify and address any areas of improvement for the environment which people lived, their support records, accidents and incident and medicines management. The manager also met regularly with the operations manager to discuss the support they needed to make the improvements where needed.

The manager told us they were aware of the concerns that we had identified within this report and the action plans we viewed during the inspection showed plans were already in place to address them. The operations manager told us the number one aim was to provide people with safe and effective care and support and they had confidence in the manager of the home to ensure this occurred.

The service user guide provided for people when they first came to the home stated the aims and values of the home. It stated; 'The vision is to enhance the lives of everyone we work with and to provide each individual with the opportunity to develop, grow and reach their potential, irrespective of their health and ability'. The staff we spoke with were aware of the aims and values of the service and told us they enjoyed their job. One staff member said, "I find the job rewarding; doing your best for people that need that bit of help." Another staff member said, "I feel as though I am helping people, it is not a chore."

Records showed that people were encouraged to become involved with decisions about the development of the service. We saw regular meetings were held with people who lived at the home and their relatives. One relative told us they felt the staff and the management listened to their views. We saw questionnaires had been sent to people and their relatives asking for feedback on the quality of the service provided. The majority of the responses were very positive. One person told us they received questionnaires to complete from time to time to give their views and staff regularly asked their opinion.

The manager, although relatively new to the home, knew people well and was a visible and active presence in the home. People and staff responded positively to her. Some of the people we spoke with knew who the manager was and told us they had spoken with them from time to time. Staff spoke positively about the manager. One staff member said, "The manager seems nice; she seems willing to get things done." Another staff member said, "The manager is nice and I hope she sticks around."

People were supported by staff who had an understanding of the whistleblowing process and there was a whistleblowing policy in place. Whistleblowers are employees, who become aware of inappropriate

activities taking place in a business either through witnessing the behaviour or being told about it.

The manager had a clear understanding of their role and responsibilities. At the time of this inspection the manager had submitted an application to become registered with the CQC. The manager understood what was required of them once they became registered. This included ensuring the CQC were notified of any issues that could affect the running of the service or people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always provide care in a safe way for service users because they had not always ensured the proper and safe management of medicines.