Cheer Health Limited

London Road Neurological & Specialist Care Unit

Inspection report

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Date of inspection visit:
16 September 2019
17 September 2019

Date of publication:
22 October 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
London Road Neurological & Specialist Care Unit is a residential care home providing personal and nursing care to 22 people. The service provides care for people with a genetic or acquired brain injury, people with degenerative conditions, and people with stroke or cardiac conditions, who require palliative and long term care. The service can support up to 33 people in an adapted building.

People's experience of using this service and what we found
Staff responsible for the administration of medicine had not had their competency regularly assessed, and did not always follow the provider's policy and procedure for the administration of medicine. Care plans and protocols relating to the administration of some medicines were not sufficiently detailed. Potential risks to people's health, safety and welfare were undertaken and implemented by staff. The environment was well-maintained and clean, and there were effective infection control measures in place.

Systems were in place to keep under review the quality of the service being provided. However these were not consistently implemented for all staff, as nursing staff were not monitored by the training manager. A system of quality assurance was in place, which included seeking the views of people and family members. Family members praised the management of the service and the quality of care provided to their relatives.

People's needs were met by sufficient numbers of staff who had the necessary skills, knowledge and experience to provide tailored care and support. People were supported to have maximum control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff worked in partnership with a range of health care professionals, who along with people's family members were fully consulted in care decisions, to ensure the best outcomes for people.

Family members spoke highly of the kindness, respect and compassion offered to their relatives and themselves, by all the staff. Staff were highly committed to providing and maintaining people's privacy, dignity and independence.

Staff were committed to providing people with highly personalised care, based on their knowledge and understanding of their needs. Staff were able to identify and respond to people's changing needs, which included where people were not able to communicate these themselves. This included staff being able to support people with the management of pain, their symptoms and end of life care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 14 March 2017)

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvement. Please see the safe section of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for London Road Neurological & Specialist Care Unit on our website at www.cqc.org.uk.

Enforcement
We have identified a breach in relation to the management of people's medicines.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

London Road Neurological & Specialist Care Unit

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team comprised of one inspector, a Specialist Advisor and a member of the CQC medicine team.

Service and service type
London Road Neurological & Specialist Care Unit is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had about the service, this included notifications. A notification is information about important events the service is required to send us by law. The action plan set out how the provider planned to make the improvements to meet the regulations.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used the information in the provider sent to us in the Provider Information Return.

We sought feedback from commissioners for health and social care who fund the placements of people at the service and asked them for their views.

During the inspection
We spoke with one person who used the service and four family members about their experience of the care provided.

We spoke with the registered manager, two nurses, six care workers, the activity organiser and the chef. We spoke with a physiotherapist who provides support to people at the service. We spoke with the nominated individual, referred to as the provider in this report. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Staff did not have the information available on how to prepare and administer medicines given via a feeding tube safely. Where people needed medicines "when required", there was no record of how to identify when people needed their medicines if they could not communicate verbally.
- We saw a nurse sign two medicine administration record (MAR) charts after they had administered somebody else's medicine. This is not good practice and against the providers own policy.
- Nurses administered antibiotics for people, which had been prescribed in advance, without first consulting with a doctor or without guidance from an individualised care plan or protocol.
- Staff did not make a record of where a medicinal patch was applied, therefore, there was no assurance that the patches were applied in accordance with manufacturers guidance. Staff that were giving people their medicines had not received training or an appropriate competency assessment around this role in the last three years.

These findings evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

- Staff had completed safeguarding training, they knew how to report any concerns and were confident these would be properly dealt with by the registered manager. Staff were aware of external stakeholders they could contact about safeguarding concerns, which included the local authority, the police and the Care Quality Commission (CQC).
- Information about safeguarding was displayed throughout the service, for the benefit of staff and visitors.

Assessing risk, safety monitoring and management

- Potential risks to people were assessed, were regularly reviewed, and covered a range of areas which included, the risk of malnutrition, dehydration, choking or aspiration and skin integrity. Assessments identified how the level of risk was to be reduced, and clearly documented the action staff were to take to promote people's safety.
- Staff were aware of the potential risks to people, and followed the agreed guidance to promote people's safety in a number of ways. For example, by using the appropriate equipment to move people safely, the procedure for supporting people on an individual basis when eating so as to reduce the risk of choking, and the use of pressure relieving equipment to promote good skin integrity.
- People's capacity was assessed when decisions were made about potential risks. Where people were found not to have capacity, best interest decisions were made involving family members and health care

professionals.
● Family members told us how staff promoted the safety of their relative, which included regular observational checks on their well-being. A family member told us, "They check on [relative] every half an hour, and more frequently when they are sitting in their chair, as opposed to being in bed."
● Systems were in place to ensure equipment within the service was maintained. For example, fire systems, moving and handling equipment and utilities such as electrical installation, gas and water.

Staffing and recruitment
● Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people, which included a Disclosure and Barring Service check (DBS). The DBS assists employers to make safe recruitment decisions by ensuring the suitability of individuals to care for people. Records were in place to evidence nursing staff were registered with the Nursing and Midwifery Council (NMC).
● The registered manager had oversight of staffing levels, to ensure people's needs were met in a safe and timely way, this included both nursing and care staff. The registered manager reviewed staffing levels, which were linked to people's needs as identified within their assessments and care plans. The staffing rota was planned to ensure the skill mix and knowledge of staff to promote consistent and safe care.
● Staff received training in topics related to the promotion of people's safety. For example, staff took part in fire drills, and practiced using the equipment they would need to evacuate people in an emergency.

Preventing and controlling infection
● Procedures were in place to protect people from the risk of infection, which included staff being employed to follow a robust cleaning schedule.
● Staff have received training in infection control, and were aware of the importance of using personal protective equipment (PPE), such as gloves, aprons and hand sanitizer. Staff told us they washed their hands, and changed their PPE once they had completed the care and support of one person, before they provided support to someone else.
● Family members spoke of the importance of cleanliness, and that it had been one of the reasons they had chosen the service. A family member said, "We looked around a number of homes, this one stood out for us in many ways. One was because it was clean, and there were no unpleasant odours."
● The food standards agency had visited in September 2018 and awarded the kitchen a 5-star rating of very good. (The ratings go from 0-5 with the top rating being '5').

Learning lessons when things go wrong
● A system was in place to record accidents and incidents. Records showed there were very few incidents involving people using the service, and no trends or themes had been identified.
● External safety alerts and information received by the service, for example about equipment or medicine were reviewed. Consideration was given to the alert and whether it affected the service. Where action was needed this was recorded. For example, action had been taken following an alert related to equipment used to administer medicine.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments were undertaken to ensure the person's needs could be met, in most instances this included visiting the person in their current place of residence, often within a hospital setting, and speaking with family members and health care professionals.
- Family members told us they had been fully involved in the assessment of their relative, and had contributed significantly to providing information with regards to their health and welfare.
- Assessments identified if equipment was required to meet a person's needs. The service had a range of equipment to promote and maintain people's health and welfare, which included a range of individual chairs, tailored to meet individual needs, as well as equipment to be used in an emergency.

Staff support: induction, training, skills and experience

- Care staff underwent a comprehensive and planned period of induction with support from the training manager, which included booklets providing information about the induction process and what it entailed. The information outlined the expectations of the provider by ensuring staff had the key skills and knowledge to deliver effective care.
- Staff completed the Care Certificate during their induction, along with training in key areas to enable them to meet the specific needs of people at the service.
- There was a systematic approach to the ongoing training and assessing of care staff's competence to deliver and provide the care people using the service required. This took place in the form of internal and external training and observed practice.
- Nursing staff undertook training specific to their role, and were required to evidence their competence to the Nursing and Midwifery Council (NMC) to enable them to remain registered as nurse practitioners.

Supporting people to eat and drink enough to maintain a balanced diet

- Assessments identified people's needs with regards to food and drink, and their dietary and fluid intake was monitored and kept under review.
- Specialist diets to meet people's needs were provided. For example, diets to support medical conditions such as diabetes. Dietary requirements were also considered based on people's culture or beliefs, and information as to food allergies such as lactose intolerance were recorded.
- Menus were in place reflective of people's needs, and took into account other dietary requirements, which included portion sizes and the texture of food. For example, some people ate a liquidised or soft diet.
- Where people received their nutritional needs via an alternative method, for example a PEG feed, (this is where nutrition is given directly into the stomach via tube a tube.) We found clear guidance to be in place to

meet individual needs.

Staff working with other agencies to provide consistent, effective, timely care support
● People's needs were assessed in a timely manner, to support the discharge of people from hospital into the service. Information was available to accompany people should they need to be admitted to hospital in an emergency. However, we identified improvements could be made to the range of information and its accessibility to support the smooth transfer of information. The registered manager agreed to make changes.

Supporting people to live healthier lives, access healthcare services and support
● People's needs were kept under review and documented, and any changes in people's wellbeing was acted upon. Staff were aware of people's individual needs, and knew that any small change could be an indication that the person was unwell. For example, if they appeared flushed or their behaviour changed, such as an increase in coughing or changes to their breathing.
● Family members we spoke with expressed confidence in staff to react to changes in their relative's health, and told us they were kept fully informed of any concerns and the actions taken by staff.
● People were supported by a range of health care professionals, which included doctors, speech and language therapists, and physiotherapists. Staff liaised with health care professionals, who provided support in specific areas, which included pain and symptom management and enteral feeding (delivery of food supplements direct into the stomach).

Adapting service, design, decoration to meet people's needs
● People in most instances, due to their significant health needs stayed in their room. Where people did leave their room there were a number of communal rooms which people could use, which included a large communal room on both the ground and first floor, and a conservatory.
● A family member told us that when they visited, they took their relative into the garden in their chair, and also spent time in the conservatory with them.
● Bathing and shower facilities were provided to meet the needs of people, along with equipment to enable people to access these.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We found conditions were being met, which were monitored by an independent person, appointed by the authority who had authorised the DoLS, known as a Paid Person's Representative.
● People's capacity to make informed decisions about their health, care and welfare were assessed. Where assessments had identified people did not have the capacity to make an informed decision, then a best interest decision was made on their behalf. Best interest decision meetings involved health care

professionals, staff from the service and family members.

● Family members told us their views had been sought with regards to the treatment and care of their relative, to ensure any interventions were in their best interest.

● A majority of people at the service, who did not have the capacity to make an informed decision had an authorised DoLS in place, which placed restrictions on them, with regards to the receiving of care and treatment, which included the administration of medicine and all care interventions.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Family members were consistently positive about the kind and caring approach of all staff towards their relative in the delivery of care. A family member told us, "I can't praise them [staff] highly enough, they're lovely." Another family member told us, "Care has been excellent, and the staff are amazing, and I mean all staff, when the laundry staff walk past, they always pop their head in and say hello."
- Staff spoke compassionately about the people in their care, and were fully aware that many of the people had limited consciousness. Staff said it was therefore important to always talk with people as though they could fully understand what was being said, which included explaining all the care they were to provide, before each care intervention.
- Staff responded in a timely way, when people required assistance. For those people who could not request assistance, staff carried out regular checks throughout the day, so that any changes in people's needs could be responded to.

Supporting people to express their views and be involved in making decisions about their care

- Family members told us they were fully involved in all decisions, regarding the health, care and welfare of their relative, and shared with us in detail the support their relative received. They told us they were involved in meetings, with health care professionals and staff from the service to discuss and agree the care and treatment of their relative.
- Family members told us the caring approach of all staff also extended to them as well as their relative. A family member told us, "Staff have been very supportive, provided a shoulder to cry on. [Registered manager] has been very helpful." A second family member said, "All staff ask how we are, which is very much appreciated."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was key to the approach of staff towards care. Staff were fully committed to the promotion of people's privacy and dignity in all care interventions, and their competency was regularly assessed to ensure this was maintained. A member of staff told us, "The training manager observes us delivering care, which includes personal care, she ensures we promote people's privacy and dignity and provide support consistent with our training."
- Staff had a clear understanding of people's care needs, which included when people experienced pain. Staff told us how in some instances people were able to verbally express pain, whilst others communicate via gesture. Staff were fully aware how to observe for potential pain, for those people with no communication. For example, by people's facial expressions. Staff in these circumstances would use their

knowledge of people to identify the location of the pain, and seek the advice of nursing staff, so the appropriate steps could be taken to alleviate the persons pain or discomfort.

● People's independence was promoted, as part of their care and treatment. The physiotherapist along with other health care professionals supported people to regain their independence. For example, through passive movement of limbs, to maintain or encourage flexibility and muscle tone. A person told us they had been assessed for an electric wheelchair, which they hoped would increase their independence.

● Staff, whilst supporting independence also acknowledged when people required support. For example, a family member told us how their relative was supported to eat independently, however staff took over when they noted they had become tired, and were struggling to eat.

● A family member told us of the improvements their relative had made since moving to the service, which included being introduced to a soft diet, having previously received their nutrition via a tube directly into their stomach. They told us of the positive impact this milestone had had, on both them and their relative.

● A family member told us, "Privacy and dignity is provided in a subtle way, staff look at people as individuals. Staff have got to know [relative], and [relative] laughs with them."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and take part in activities that are socially and culturally relevant to them

- People were supported to take part in activities by the activity co-ordinator. Activities were tailored to meet the individual needs of the person, which included supporting people with passive movements to support physical well-being, and games to support cognitive thought, and promote movement of hands and limbs. For example, by playing dominoes. The activity organiser considered people's cognitive abilities, by placing the dominoes in a specific way so as the images of the dominoes could be understood and interpreted.
- People in most instances remained in their room, due to their needs. People were observed watching television or had music playing in the background, which included prayers to support people's religious needs. People had the opportunity to visit a local Church with the support of staff, and a Vicar regularly visited the service.
- Staff acknowledged and celebrated events, which included people's birthdays. A cake was baked by the chef, and staff and family members sang happy birthday. Christmas and New Year were celebrated. Family and friends were asked to join their relatives for a meal, and at Diwali, the chef prepared desserts for those who celebrated.
- Family members spoke of the 'family atmosphere' at the service. A family member told us, "It's a very family orientated environment, our grandchildren and the family dog are always made to feel welcome." This was echoed by staff, one staff member told us, "It's a family atmosphere and a helpful, and caring environment."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Family members were supported and encouraged to contribute to the planning of their relatives care and treatment, which was person centred to ensure individualised care was provided.
- Staff were fully aware of people's dependence on their support, and where possible took the appropriate steps to support their independence. A family member told us, "Staff give [relative] their toothbrush and encourage them to brush their teeth." We also saw how staff ensured people were able to use equipment to request assistance. For example, a person showed us how staff placed the call bell into their hand, along with a tube connected to a drink. They told us this meant they were able to request assistance when it was required, and that they could have a drink independently without the need to call for staff support.
- Family members were aware of the prognosis of their relative, which for some relatives focused on improvements to their independence and health. Whilst for other family members, they were fully aware that their relative's health would deteriorate and that care and treatment would need to change to accommodate this. Family members spoke openly with us about their relative's future with regards to care,

which included making plans for end of life care.

End of life care and support

● At the time of the inspection no one was actively receiving support with regards to end of life care. The majority of people or their family members had made decisions, which included having in place a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). People's capacity to make informed decisions about DNACPR's were documented.

● A family member told us when the time came, they would speak with staff about their wishes for their relative, they had confidence that staff would provide the support and care their relative would need, and told us a DNACPR had been put into place.

● Medicines to support people were in place to support with symptom and pain management. End of life care plans were developed with the involvement of family members, and would include any specific requirements or preferences, and would reflect people's beliefs, culture or religion.

● The registered manager informed us, family members were always kept informed when a person's health deteriorated, and were encouraged to spend time with their loved one both during, and after death. Staff would support the family during this time.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff had knowledge of people's care, including a clear understanding as to how people communicated. Whilst some people were able to communicate verbally, some communicated via gesture. Staff told us, to assist people with communication, they always ensured any equipment prescribed such as hearing aids or glasses were in place.

● Staff told us, a key part of their role was to be observant and note any changes, however small, as many people had very limited or no ability to communicate. This meant staff used their knowledge and familiarity with people to detect any changes, such as expression of pain or discomfort. For example, changes in people's ability to swallow, any changes to colour or condition of their skin, or general alertness.

● A family member told us, "Staff are very patient and professional. They interpret [relative's] needs, even facial muscle deterioration. They can pre-judge their pain, and the start of them becoming unwell, for example a cold or infection, at which point, nursing staff commence treating them with anti-biotics, which are kept on-site."

Improving care quality in response to complaints or concerns

● Family members expressed confidence in raising a concern or complaint, and told us any minor concerns had been quickly addressed.

● The complaints procedure was displayed on the notice board, and was included within the services, service user guide, a copy of which was in each person's room.

● The provider had received one complaint from an external source in the last twelve months. The registered manager had liaised and provided the information requested by social services who investigated the concern. The outcome of the investigation had been used to reinforce the importance of providing clear information when requested by emergency services.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The provider's system to keep under review the day to day culture of the service, was not consistently implemented for all staff. For example, nursing staff's competence to administer and manage medicine was not kept under review. However, the system was effective for care staff, as they were supported through ongoing training and assessment of their competence in a range of areas related to the delivery of care through observed practice.
- We found improvements could be made to ensure staff consistently accessed, reviewed and implemented good practice guidance. For example, the annual assessment of staff to ensure their competence to administer medicine. The registered manager informed us, they would set up meetings to specifically focus on good practice guidance, and to review how any changes required would be implemented and shared with all staff.
- The nominated individual and registered manager had attended local events to share good practice, and talk about local issues
- Staff spoke positively about the management of the service, and spoke of the support provided by the management team, who were always available to offer guidance and support. Staff told us they worked within a supportive and caring environment, with staff working together effectively as a team. Family members spoke of the team work exhibited by staff. A family member told us, "They [staff] all get on, you never hear any animosity between them. It supports our views of the family atmosphere."
- People and relatives told us they were extremely happy with the service and that people received professional, personalised and good quality care. A family member told us, "We chose this home for our [relative]. They had previously stayed here for respite care. Staff give us the confidence we need, so that we can walk away knowing they [relative] are safe and well cared for."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider and registered manager were aware of their responsibilities under the duty of candour, and where required shared information consistent with their responsibilities. For example, they submitted notifications to the Care Quality Commission (CQC) and where required to other stakeholders, for example in relation to safeguarding concerns.

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements

●The service had a clear management and staffing structure, with all being aware of their individual roles and responsibilities. The registered manager fulfilled their regulatory requirements by submitting notifications to CQC about events and incidents as they are required to do by law. The previous inspection rating and report was referenced on the provider's website, and displayed on the notice board, along with other reports reflecting the quality of the service as published by commissioners.

● A range of audits to check and assess the quality and safety of the service were regularly carried out. Information and identified trends were analysed by the registered manager with actions identified to ensure people were protected and safe.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's views and that of family members were sought through surveys, which were sent out annually. Surveys completed by family members showed a high level of satisfaction with the service provided, with family members having included additional comments praising the quality of care and the professionalism of the staff. For example, 'We cannot thank you all enough for the excellent care everyone gives, we really appreciate the way we are kept informed about everything. We also appreciate the happy friendly atmosphere. Bless you all.'

● The provider had systems to support and care for staff. Staff were kept informed about the service through staff meetings, and surveys sent to staff, seeking information about their wellbeing, this was part of the provider's commitment of support.

● The provider had taken part in the National Care home open day earlier in the year, and had invited family members and friends to visit the service and take part in the organised events.

● Family members had posted positive reviews about the quality of the service on websites, designed to enable people to independently comment upon care services.

Working in partnership with others

● The registered manager and staff worked closely with multi-disciplinary teams to ensure people received effective, joined up care, which included seeking the support and guidance of other health care professionals, with specific areas of expertise. For example, end of life care and specific degenerative conditions.

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 provider must ensure that the appropriate information around medicines is available for all staff supporting people with their medicines safely. The provider must ensure that all staff involved in supporting people with their medicines are trained and competent to carry out this role.