Jennifer's Lodge Residental Care Home

Jennifer's Lodge

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 and 26 April 2018 and was unannounced.

At the last inspection on 15 February 2017 the service was rated Requires Improvement. Following the last inspection, we asked the provider to send us an action plan to show what they would do to improve the key questions Safe, Responsive and Well-led.

Jennifer's Lodge is a residential care home for older people with mental health needs and dementia. 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 care home accommodates six people in one adapted building. At the time of the inspection there were six people living at the home.

The premises is laid out over three floors. Communal areas included a lounge, dining room, kitchen and a separate laundry area. There are shared communal bathrooms that are suitably adapted. At the rear of the home is a large garden that is accessible through patio doors.

The service had a registered manager who was available on both days of the inspection. 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.

Although the systems were in place to safeguard people from abuse and the correct action taken, the Care Quality Commission (CQC) had not been notified of an allegation of abuse when this had occurred. Sufficient guidance was in place about the actions staff needed to take to make sure risks were safely managed.

A routine fire safety inspection had been carried out in the service and the provider agreed to send us a plan of action. Health and safety checks had been carried out on the premises.

People received their medicines when this was needed and staff had received training on the safe management of medicines.

There were enough staff deployed to work in the service who had been suitably recruited. Training was available for staff to ensure they had the skills and knowledge to provide effective care for people. Staff had received regular supervision and appraisals.

People gave us positive feedback about the quality of the food. They were provided with sufficient food and drink; however, menus were not displayed during mealtimes so people could choose what foods they would

like to eat. Information was not available in an easy read format so they could better understand the services they received.

Routine visits were carried out by health practitioners to offer advice and treatment for people to meet their medical needs.

People and their relatives told us staff were kind and caring and their privacy was respected. Advocacy services were accessible to ensure people had their views heard.

Systems were in place to monitor complaints and informal complaints that were raised had been resolved. The provider had discussions with people about end of life care and documented their advanced decisions in line with their wishes.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Although the service was meeting these requirements, they had not notified the CQC where a person's liberty was restricted in their best interests.

People were supported to maintain positive relationships with their relatives and friends. They were provided with opportunities to participate in a programme of activities. People's cultural and spiritual needs were met and their care plans were personalised to meet their assessed needs.

People's feedback was sought about the quality of care. Checks were carried out and audits undertaken to monitor how care was being delivered but some audits were not always consistently recorded. People spoke favourably about the management of the service. The provider worked with external stakeholders to deliver effective care for people to ensure their medicines outcomes were met.

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

Aspects of the service were not always safe.

Although health and safety checks were carried out in the home, recommendations by the fire safety authority required action.

Staff knew the correct action to take to keep people safe from abuse.

Risk's associated with people's healthcare needs were managed to ensure people were protected from harm.

Recruitment checks were undertaken on staff to assess their suitability for their roles. There were enough staff employed to provide people with a consistent and flexible service.

Medicines were administered safely and effectively. Processes were followed to manage the administration, storage and disposal of medicines.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

People's capacity had been assessed and best interests meetings held to ensure that people's rights were protected in relation to consent.

Although people's nutritional requirements were met, but people were not offered a choice during their mealtimes.

Staff had received training and there was a plan in place to ensure further training and support was completed frequently.

People had access to healthcare professionals to give them advice, treatment and support when this was required.

Is the service caring?

Good

The service was caring.

People were supported to express their views and be actively

involved in making decisions about their care.

Staff understood people's care needs and the things that were important to them.

People's relatives told us their family members were supported by kind and caring staff who respected their dignity and privacy.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and focused on people's individual needs, and staff supported people to maintain their independence.

Advanced decisions were included in people's records in line with their wishes.

Complaints were responded to when people had concerns about their care.

Is the service well-led?

Requires Improvement

Aspects of the service were not always well-led.

The provider failed to inform the Care Quality Commission (CQC) of notifications in relation to safeguarding and DoLS as required by law.

Although audits had been carried out on the service to assess the quality of care provided, some records were not reviewed.

Feedback had been sought from people and health professionals to obtain their views about the service.

The provider worked jointly with other services in the local area and the local authority to seek advice and support.

Jennifer's Lodge

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.

We inspected Jennifer's Lodge on 24 and 26 April 2018. The inspection was unannounced on the first day and we told the provider we would be returning to continue with the inspection for a second day. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we liaised with a representative of the London borough of Lewisham who provided information about the quality monitoring of the service.

We checked information that the Care Quality Commission (CQC) held about the service including the last inspection report and any notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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During the inspection we spoke with four people and three relatives and spent time observing the care people received in the home. We reviewed the provider's action plan and checked five people's care files and their medicines records. We spoke with one care worker, the deputy manager and the registered manager. We also checked four staff training and recruitment records, quality audits, minutes of meetings and some of the key policies and procedures.

We found one breach of regulation in relation to notification of incidents. We also made one recommendation about people being involved in the planning of meals and information being accessible to people in an easy read format. You can see what action we asked the provider to take at the back of the full version of this report.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that health and safety checks in relation to fire safety and emergency lighting were not always carried out to ensure people lived in a safe environment. During this inspection we found the provider carried out checks in the home to minimise the risk to people's safety. An external contractor had carried out annual safety checks on the fire equipment and lighting in the service. Weekly testing on emergency lighting had been completed to check this was in working order. There was evidence of weekly fire safety checks in the home. This included visual checks on the fire panel, fire extinguishers and exit routes and the records showed no gaps. A fire drill had been carried out in January 2018 and records evidenced that staff had completed fire safety training. The registered manager explained that a fire safety officer had visited the home to carry out a routine fire safety inspection on 6 April 2018. They said they were advised that the fire risk assessment and evacuation plan, should be completed by an external organisation. After the inspection we received a copy of the fire safety order with recommendations to be actioned by September 2018. This included that the provider was required to provide fire detection equipment on the ground floor, fire doors to effectively self-close into their frames, removal of domestic appliances from fire exits and to carry out a more throughout and in-depth risk assessment. We asked the provider to send us a copy of the action plan addressing the identified issues. After our inspection the registered manager sent us their action plan to address how the recommendations would be met.

At the last inspection we found that there was no clear guidance and training in place to manage the risk to a person's percutaneous endoscopic gastrostomy (PEG) tube. During this inspection we spoke with a person about their PEG who commented, "The carers manage my PEG, I'm nil by mouth." We found the risk assessment in relation to the person's PEG tube had been updated and reviewed within the last 12 months. The risk assessment evidenced instructions and guidance were in place for staff to follow to mitigate risks. For example, instructions showed what staff should do if the skin became infected; how to flush and change the tube and the actions care workers should take if the person experienced discomfort at night. There was a tube passport in place that included input from the district nurse and dietitian. In the event the provider needed advice about the PEG, records held the details of key contacts from the home enteral nutrition (HEN) team, who staff had liaised with and the HEN team had offered their support. The district nurse from the HEN team had carried out training for the staff team to show them how to manage the person's PEG effectively. The staff we spoke with were clear about their responsibilities regarding the PEG, such as the times the person required feeding and the amount and temperature of water required when flushing water through the PEG tube.

Risk assessments were in place and updated to show how risks could be managed to reduce the likelihood of harm. Assessments had been produced to show how risks affected people's wellbeing and health and what measures had been put in place to manage these. Records included information about what actions care workers were required to take in relation to people's nutrition, medicines, physical health and mobility. For example, where one person had a fall and was seen by a GP, their records had been reviewed and included written instructions for staff to apply a pain relieving gel to their knee to reduce their discomfort and help prevent further falls.

At the last inspection we found the provider did not carry out thorough recruitment checks. During this inspection we found that recruitment checks had been carried out on all the staff who worked in the home. The registered manager told us they recruited potential employees through word of mouth and had linked up with the local college to recruit more employees for care worker roles. They said they no longer employed volunteers.

Recruitment checklists were held on staff files to ensure all the required background checks were obtained for candidates and to demonstrate that a systematic audit had taken place. This included a completed applications form, an interview assessment and photographic identification. References were sought from previous employers and were verified by a company stamp and/or a phone call to the referee to ensure the references were authentic. Disclosure and Barring Service (DBS) checks were undertaken on employees. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. Records showed that one staff member was working in a non-caring role. Whilst the provider was waiting for their DBS check a risk assessment was undertaken to show they were supervised to carry out domestic duties only in the service.

At the last inspection we found the provider did not keep a proper record of people's finances. During this inspection we found the provider had updated their system for people's expenditure. Where relatives managed people's finances they had agreed with the provider to hold a monthly budget, to purchase any additional items that people required. We checked two people records and found there was a monthly spending sheet with a record of people's expenditure' with attached statements of accounts and the receipts. We reconciled people's finances and found these to be accurate. These systems helped to ensure that people were protected from the risk of financial abuse.

There were enough staff deployed within the home, and a relative commented, "There is always enough staff in the home and the phone is always answered when I call." People told us there were enough care workers to help them when they called for assistance on their call bells. One person said, "Carers come when I ring the bell" and "I haven't had a need for the buzzer, there are enough staff." We checked the calls bells and found they were placed within easy reach of people in their rooms and in working order. The rota showed there were six care workers, two domestics, the deputy manager and the registered manager who covered the working hours in the service. There were three members of staff on duty who worked in the day time and three during the night-time. At the time of our visit there were no staff vacancies in the home. We observed that when people asked for support there were enough staff to support them and respond promptly to their needs.

People we spoke with told us they felt safe and comfortable living in the home. One person said, "I feel comfortable and safe, no one will take my stuff," and another person commented, "I am safe because no one can get in and get my possessions". And people's relatives commented, "There is no better place, we tried seven other care homes they were no good. I wouldn't leave [my family member] in a place that was no good" and "[My family member] is very happy and feels safe, they are very pleased and gets on well with all the staff."

Care workers we spoke with told us they understood what abuse was and how they would report any concerns that they had. There was a safeguarding policy to guide staff on the actions they should take if they witnessed or suspected people were at the risk of harm. Staff told us they had received training in safeguarding and the records we reviewed confirmed this. The registered manager explained there had been one allegation of physical abuse by one person towards another in the home. Although the provider had informed the relevant authority and preventative measures had been put in place, they had not notified the Care Quality Commission (CQC) of the allegation of abuse as required by law.

People received their medicines as prescribed. Medicines were stored in a locked cupboard and there was a current edition of the British National Formulary (BNF) book available for staff. The BNF is used so that staff can remain up to date with the latest information about medicines, their uses and side effects. People's medicines were contained in blister packs delivered by the pharmacist and stored at the correct temperature. We checked people's medicines records and found that staff had signed the medicines records when people had been given their medicines. Topical medicine administration records showed where creams required application to a person's skin. Creams and liquid medicines were labelled with the date of expiry to ensure staff knew when to dispose of these. We conducted a stock medicines count of tablets contained in packets and found these to be accurate. At the time of the inspection the provider told us they were not supporting people with controlled drugs.

Infection control measures were followed to minimise the spread of infection. People told us the home was regularly cleaned. Their comments included, "The staff clean my room every four days" and "They clean my room regularly." Notices were displayed in communal bathrooms to remind staff about the importance of hand washing to minimise the spread of infection. We observed the home was clean and free from malodour and that staff washed their hands before carrying out any practical tasks. Personal protective equipment such as aprons and gloves were readily available for staff when this was required. Staff told us how they maintained and cleaned equipment with frequency to maintain safe hygiene standards.

The provider was able to demonstrate that they learned from incidents at the service. For example, where one person displayed behaviour that challenged the service the provider had contacted relevant health professionals to request support for the person and staff. As a result a positive behaviour plan was implemented and followed by the staff. They said this had helped them to understand the triggers that caused the person's behaviour that challenged and what action staff should take when the person's behaviour gave cause for concern, which had led to a reduction in incidents.

Requires Improvement

Is the service effective?

Our findings

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 Mental Capacity Act (MCA) 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of (DoLS). Although a DoLS application had been granted where one person had been deprived of their liberty in their best interests, the provider did not notify the CQC a DoLS had been authorised by the supervisory body in August 2017. After the inspection the provider submitted the notification to the CQC.

The provider was working in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Consent forms had been signed by people to show they had agreed to the care and support they received. For example, people had agreed to have their photograph taken and displayed in their file. Where one person required an assessment when their mental health had deteriorated the provider had made a referral to the mental health and older person's team. They had been assessed by a multi-disciplinary team and preventive strategies had been put in place. For a second person an MCA assessment was carried out by the mental health team to demonstrate that the person could make specific decisions about their day to day care. For third person a best interests checklist was carried out by the community practice nurse and social worker. This was to assess what they needed to consider before establishing what action needed to be taken where the person lacked the capacity to make specific decisions for themselves. For example, in relation to their finances.

People told us they enjoyed the food at the service. One person said, "The food is good and the drinks" and when one person was served their meal they commented, "Look at this, it's delicious."

Although people were happy with their lunchtime meal, people were unclear about what they were going to eat or what choices there were. People commented, "I have no idea, what's for lunch?" and "Meals, I don't know when they do it, no menu choice." We pointed this out to the registered manager who showed us the menus but these were stored on a shelf. The menus included a variety of meals and alternative foods that were available. They agreed to display the menus during people's mealtimes so they could be kept informed about their mealtimes. The registered manager told us they spoke with people about their meal choices however there were no records to demonstrate that people were involved in discussions about the menu planning. We noted that the menus were not provided in an easy read format if people requested this to help people understand the food choices available to them. We recommend the provider updates their information in accordance with the accessible information standards to ensure people are provided with information they can easily read and involve people in the planning of the menus.

We observed the lunchtime meal saw that people were encouraged to eat a well-balanced diet. There were good sized portions of food served and people were offered second helpings. People's food preferences and dietary needs were recorded so that staff could check the preferred dishes and the variety of meals people chose to eat. Where people required support to eat specific diets, the records we looked at and observations we made showed that these were being followed. For example, for one person we noted that their eating and drinking care plan was being followed, they were given food supplements and we saw the dietician had reviewed their dietary requirements.

Care and support was delivered in line with good practice and monitored to ensure medicines were managed safely. The provider worked jointly with the Lewisham Integrated Medicines Optimisation Service (LIMOS) who offered advice and support in relation to outcomes for the safe management of medicines. This included a review of people's medicines and input into their medicines care plans. We found these contained written instructions on the safe administration, storage and disposal of medicines. LIMOS worked with the provider to ensure their medicines policy was reviewed and up to date. They had also supported the senior managers with training on anticoagulant medicines as part of a medicines workshop. Anticoagulants are medicines that help prevent blood clots. The deputy manager told us the training and input from LIMOS had been extremely useful.

Staff had completed sufficient training and were supported in their roles which enabled them to deliver effective care to people. Care workers had completed an induction that included a practical guide regarding the orientation of the home, the providers' facilities and their policies. The registered manager explained that new employees shadowed other experienced members of staff to observe how care should be carried out specifically to meet people's individual needs. Care workers who had worked in the home for a number of years had completed the common induction standards when they were first employed. Staff records evidenced they received training in topics including moving and handling, malnutrition, first aid, infection control and safeguarding. Regular supervision and appraisals were planned and organised with staff to give them the opportunity to reflect on their work performance and discuss their development needs. Staff had obtained or were in the process of completing a national vocational qualification in health and social care.

People told us they had access to healthcare to help them with their medical needs. Relatives we spoke with told us that doctors and hospital appointments were arranged by the provider. Care files we viewed showed that people had been appropriately referred to health care professionals such as the GP, dentists, opticians, the district nurse and the mental health team. Records contained details of people's medical diagnosis and included a recorded input from a range of health professionals. Although the provider was not supporting people who were at the risk of pressure ulcers we found specialist equipment such as pressure cushions were available for people to use. Where one person was at the risk of falls a sensor mat was placed near their bed, to promptly alert staff to any incidents of falls that occurred.

Good

Is the service caring?

Our findings

People spoke about the caring nature of staff who supported them in the service. They said that the staff who supported them were friendly and nice. People's relatives commented, "I'd describe them as lovely, a wonderful family they always are" and "We are quite pleased, [my family member] gets a lot of attention."

Staff understood people's preferences, likes and dislikes. Care notes held detailed information about people's circumstances and significant events in their lives. One person's notes showed the special moments in their life, and how they loved swing music and the importance of their relationship with a significant other. Care workers asked people about the clothes they preferred to wear before assisting them to get dressed and offered choices about what they wished to do. For example, after breakfast we observed the care worker asked if a person would like to watch television or listen to the radio. People were spoken with in a caring manner and staff were seen to be attentive and caring when supporting people.

People were supported to express their views and make informed decisions about their care, treatment and support and relatives were involved in decisions about their care. Care notes showed discussions about people's care and support had taken place before they moved into service. Relatives told us the service suited their family member's needs and that the care workers gave people choices about their daily routine, such as the times they liked to wake up and go to bed. People said their family and friends visited when they chose and were welcomed at the home and the relatives we spoke with confirmed this.

Plans were in place about people's bathing routines which outlined the personal care they required support with. We observed that staff paid attention to people's personal appearance such as their clothes, hair and nails when supporting them with their personal care. Records were updated to demonstrate if people had maintained or lost weight and the specific details of the foods that people required to help them with eating and drinking, such as soy milk and a soft food diet.

We observed that people's privacy and dignity was respected and when people asked for support this was carried out in an unhurried manner. People told us care workers knocked on their doors before entering their rooms and we observed this was being done. When care workers helped people with their personal care we saw that doors were closed to main their dignity and privacy. One person explained that the care workers were respectful towards them and that they also respected staff so expected this back. Confidential records were stored and held securely to protect people's personal data and right to privacy.

Information was available in different formats. For example, we saw there was a Lewisham talking newspaper for the visually impaired. All the information was held on a small device. The deputy manager told us this was plugged into a computer and it informed people what was happening in the local borough. Where one person was unable to fully express themselves verbally a communication plan was in place to highlight their communication needs. For example, there was pictorial cards to show how they expressed to care workers if they ever felt worried or lonely. A relative said, "The carers know the signs [my family member] makes if there are any health issues and they always let me know if there are any concerns."

Although people had not requested advocacy support, Advocacy services were available so people could have their voice heard about the issues that were important to them.

Good

Is the service responsive?

Our findings

At the last inspection there were large gaps in the recording of people's daily care notes. During this inspection we found that people's daily records had been regularly updated to show that care and support was delivered in line with their care plans. We checked a sample of daily notes for two months prior to our visit and these had been completed daily to demonstrate that care tasks were carried out with people, in accordance with their care plans.

Care plans contained information about people in their files such as the things they could do and what they would like help with. They provided staff with insight about people's social history, interests, emotional wellbeing and their health needs. When speaking with care workers it was clear they were familiar with the way that people wished to be supported. Staff had established this as they had gathered this information with the involvement of their relatives before they began using the service. For example, a care worker told us about a person who like to be involved with organising activities for people in the home and we saw them preparing games for people to play together.

We saw examples of care workers encouraging and supporting people to maintain their independence as far as practically possible. Prior to a lunch time meal, we saw one person was helping to peel the potatoes in the kitchen in preparation for a mealtime. Another person was engaged in a word search with a member of staff and we observed them smile when they found the correct words. The member of staff told us this helped to stimulate the person's memory and kept them actively engaged.

People were involved in the activities they enjoyed. During the day we saw that one person went out to attend the synagogue and another person told us they liked to watch movies, and commented, "The manager takes me shopping to buy my jigsaws and DVD's." Staff took people out to lunch during our inspection and people told us they enjoyed the day. An activity planner was displayed in the communal areas of the activities that people could participate in.

Care planning took into account people's individual needs. Notes had been written to inform staff about the importance of maintaining people's cultural traditions. Where people wished to maintain their chosen faith, they attended their places of worship. One person explained, "I love going to church, singing the hymns, the priest comes here sometimes." Care records listed the foods people were served in line with their cultural needs, such as British and Kosher foods. Records showed that one person liked to visit a café where they served Caribbean meals.

The provider told us there had been no written formal complaints since the last inspection. Records showed that were two informal complaints had been raised and these had been resolved. There was a complaints policy in place so people had information about how to make a complaint if they were unhappy about any aspect of the service but the policy was not available in an easy read format. One person said, "I tell [the registered manager] if I'm not happy, she listens" and relatives told us they had no complaints about the service. The policy indicated that people could raise a complaint to the Care Quality Commission (CQC) if they had any concerns about the service, however the CQC do not investigate complaints directly. We

pointed this out to the provider and who told us they would update the policy to reflect this.

Although the provider was not supporting people at end of life, advanced care wishes were written in people's care plans about how they wished to be supported with their end of life needs. There was evidence of discussions, observations and planning documented.

Requires Improvement

Is the service well-led?

Our findings

The provider did not notify us of a safeguarding incident of alleged physical abuse and a DoLS authorisation to restrict a person of their liberty in their best interests. In both cases we found that steps had been taken to mitigate any further risk to people. The registered manager told us they were not aware these had to be reported to us; we highlighted that the registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager agreed to send us the notifications; and after the inspection these were received.

At the last inspection we found that the provider did not regularly assess and monitor the systems in place. During this inspection we found that improvements had been made to health and safety checks, recruitment files, financial records and people's daily notes. We also saw that the provider had drafted a monthly audit form to show checks were being carried out. However, some audits had not been completed and did not always show a thorough approach to maintaining consistent audit checks on the quality monitoring of the service. For example, although care workers told us they were given handovers after each shift, no handover took place during our inspection and there were no records to evidence these had taken place.

At the last inspection we found that feedback was not sought from people and their relatives about the quality of the service. During this inspection we found that satisfaction surveys had been completed by people, in relation to the quality of their meals, their choices about their bedtime routines and if they wanted to change anything about the service. The provider showed us they had taken steps to analyse the information which showed a good level of satisfaction. However, where people had asked for more meal choices records showed that no action had been taken in relation to this. The registered manager told us they had just started analysing people's feedback and agreed to act on this. In the communal hallways we saw there were questionnaires for visitors and health professionals to give their feedback. We found that some forms had been completed by a visitor and two health professionals who had made positive comments about their observations of people's care. We saw records to evidence that a placement review had been carried out by a person's social worker who had commented that the home satisfactorily met the person's needs.

People spoke positively about the registered manager of the home. Their comments included, "It's alright I've not been here that long, the staff are nice. The manager, I've forgot her name. She's alright, she's been kind to me" and "The manager she's the best I'd never take advantage."

A family meeting had taken place. The registered manager told us that more family meetings would take place and had held regular discussions with people's relatives over the phone and during their visits, and the relatives with spoke with confirmed this.

The provider worked jointly with multi-disciplinary teams to ensure people's care and support was regularly

review. Quality checks were carried out by the local authority and the provider was working towards meeting any recommendations they had made.

The registered manager told us they worked in partnership with other care homes in the local area and had discussions with the managers of other homes to help support each other when they needed information and advice.

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider did not notify the Commission of incidents when they occurred in the service where they are required to do so. Regulation 18 (1)(2)(b)(e)