

Ravenswing Homes Limited

Ravenswing Manor Residential Care Home

Inspection report

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Date of inspection visit:
26 February 2018
27 February 2018

Date of publication:
16 April 2018

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

This inspection took place on 26 and 27 February 2018. The first day of the inspection was unannounced. The service was last inspected in October 2015 when it was rated Good.

Ravenswing Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 is a detached property and accommodates up to 24 older people on two floors. At the time of the inspection there were 22 people accommodated in the home.

The home had 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.

During this inspection we identified one breach of regulations. This was because the systems and processes to monitor the quality and safety of the service were not sufficiently robust; this had led to the shortfalls we identified during this inspection. You can see what action we told the provider to take at the back of the full version of the report. This is the first time the service has been rated as Requires Improvement.

We found a number of concerns regarding food safety and the safety of equipment. A number of out of date food items were stored in the fridge and the stair lift had not been serviced in line with required timescales. The registered manager had failed to notice or take action in relation to these concerns.

Records showed that fire safety training had not taken place in the service since September 2016; the registered manager could not explain why this was the case. Following the inspection we were told this training had been arranged for all staff in March 2018.

Although regular care plan audits had taken place, we found two people's care records did not contain risk assessments in relation to the way their medicines were sometimes administered, i.e. in food or drink without the person's knowledge. One person's care records did not contain a risk assessment in relation to how staff should manage the fact they were experiencing a bacterial infection; this meant there was a risk of cross infection. All of these risk assessments were put in place by the end of the inspection.

Although people who lived in the home did not raise any concerns about staffing levels, all the staff spoken with told us they needed an additional staff member each day, particularly in the morning; this was to help ensure people's needs were always met in a timely manner. The registered manager told us they would discuss the need for additional staff member with the provider.

Staff spoken with told us that they had completed training relevant to their role. Records we reviewed

showed staff received regular supervision and an annual appraisal of their performance; these arrangements help to ensure staff have the required knowledge and skills in order to provide safe and effective care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Systems were in place to help ensure people's health and nutritional needs were met. Although there was no chef in place and meals were prepared by certain care staff with appropriate training, people told us the quality of food was generally good.

People's health and communication needs were clearly documented within their care records. Staff worked in partnership with a number of health professionals to help ensure people had access to appropriate healthcare services.

People told us staff were kind, caring and respectful of their dignity and privacy. We noted policies for the service advised staff on the importance of treating people as individuals, respecting their rights and promoting people's well-being and independence.

People told us staff were responsive to their individual needs. A range of activities was provided to help maintain people's sense of well-being.

People were asked to provide feedback on the care they received through the completion of surveys and resident meetings. The summary of the most recent survey completed in July 2017 showed everyone who participated was very or quite satisfied with the level of service provided in the home.

Staff told us they enjoyed working in the home and found both the registered manager and provider to be approachable and supportive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

People who lived in Ravenswing Manor told us they felt safe.

Staff told us an additional staff member was required each morning to help ensure people's needs could be met in a timely manner; this view was supported by our observations during the inspection.

Improvements needed to be made to the processes in place in relation to food safety, the servicing of equipment, infection control and fire safety training.

Improvements needed to be made to the way medicines were handled in the service.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff told us they had the knowledge and skills for their role. Records showed staff received regular supervision and an annual appraisal of their performance.

Staff demonstrated an understanding of the principles of the Mental Capacity Act 2005. People told us, and our observations confirmed, they were able to make their own choices and decisions.

Staff worked in partnership with healthcare professionals and people had access to a range of services to help ensure their health needs were met.

Good ●

Is the service caring?

The service was caring.

People were very complimentary about staff. People who lived in the home told us staff always treated them with respect.

Staff demonstrated a good understanding of people's diverse

Good ●

needs, wishes and preferences.

People who used the service and, where appropriate their relatives, were involved in developing and reviewing plans of care.

Is the service responsive?

Good ●

The service was responsive.

Each person's records contained individualised plans of care to ensure staff knew how to meet their needs, wishes and preferences.

People were mostly satisfied with the range of activities available to them.

Systems were in place to respond to and investigate any complaints people raised about the care in Ravenswing Manor.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There was a lack of robust monitoring of the quality and safety of the service. This had led to the shortfalls identified during this inspection.

Staff told us they enjoyed working in Ravenswing Manor and found the registered manager to be supportive and approachable.

Feedback was sought from people who lived in the home through surveys and resident meetings.

Ravenswing Manor Residential Care Home

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 26 and 27 February 2018; the first day of the inspection was unannounced. The inspection team on 26 February 2018 comprised of an adult social care inspector, an assistant 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. An adult social care inspector and assistant inspector returned on 27 February 2018 to undertake the final day of the inspection.

In preparation for our visit we contacted Healthwatch, the local authority contracting unit and safeguarding team for feedback and checked the information we held about the service and the provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

When planning the inspection 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.

During our inspection, we spent time in communal areas observing how staff provided support for people to help us better understand their experiences of the care they received.

During the inspection, we spoke with eight people who lived in the home, three relatives, the registered manager, three members of care staff, the housekeeper, the maintenance person and the staff member responsible for cooking meals on the second day of the inspection (they were also employed as a member

of care staff). We also spoke with two visiting healthcare professionals.

We had a tour of the premises and looked at a range of documents and written records including a detailed examination of three people's care files and medicines administration records (MARs), four staff personnel files and staff training records. We also looked at a sample of policies and procedures, complaints records, accident and incident documentation, meeting minutes and records relating to the auditing and monitoring of service provision.

Is the service safe?

Our findings

We identified concerns in relation to both the safety of equipment and food safety. When we checked the certificates which confirm equipment has been maintained and serviced in accordance with the manufacturer's instructions, we found the stair lift in use had not been serviced in September 2017 as required. This meant we could not be certain it was safe to use by people who lived in the home. Before the end of the inspection, the registered manager had made arrangements for the stair lift to be serviced the day after the inspection concluded.

When we checked the fridge, we found a number of food items were out of date. In addition, not all food items contained a label to show when they had been opened; this meant we could not be certain they were safe to use. When we discussed this with the registered manager, they made immediate arrangements for the disposal of all these items. In addition, the temperature of food served to people in the home had not always been recorded. This information is important to confirm relevant food safety standards have been met.

Records we reviewed showed eight of the 17 staff employed in the home had not received training in fire safety. Eight of the remaining nine staff had not received any refresher training since September 2016. In addition to the lack of fire safety training, we were initially told no fire evacuation drills had taken place at the home since the home opened. However, records we were sent following the inspection showed fire evacuation drills had been carried out by staff in June and August 2017. The registered manager also informed us that fire safety training had been arranged for all staff in March 2018.

Although people who lived in the home did not express any concerns about staffing levels, all the care staff we spoke with told us they believed an additional member of staff was required at least each morning. They told us the increased dependency levels of people who lived in the home meant they had little time to spend with people; this view was supported by our observations during the inspection. When we discussed this with the registered manager they told us they would speak with the provider in order to add an additional member of staff to the rota each day.

We looked at the medicines administration record (MAR) charts for three people, including the records relating to the administration of prescribed creams. We noted one person's MAR chart included an instruction from their GP to stop a medicine for one week on 14 February 2018. However, we noted this medicine had not been administered for a total of 13 days. We were initially told this was because staff had been trying to get a stock of this medicine from the GP. We noted the MAR chart indicated a stock of this medicine had been received on 7 February 2018 and therefore asked staff to check this. Staff confirmed that sufficient stock had been available for the person to receive the medicine as requested by the GP. This meant the person's health had potentially been put at risk unnecessarily.

We saw that records relating to the administration of prescribed creams were fully completed. However, we noted two people were having creams administered which were not on their current prescription. The registered manager told us this was because the creams had been prescribed when the people concerned

were in hospital. However, they acknowledged that there should have been more robust checks to ensure the prescriptions received following each person's return to the home were a complete record of all prescribed medicines.

Two people's care records indicated prescribed medicines were sometimes given in food or drink, following a meeting which confirmed this was in their best interests. Although staff told us they always remained with each person when medicines were administered in food or drink, we found there were no risk assessments in place to help keep people safe when medicines were administered in this way. We discussed this with the registered manager and noted these risk assessments had been completed prior to the end of the inspection.

We noted the registered manager was completing at least annual assessments of relevant staff member's ability to handle medicines safely.

People spoken with told us they felt safe living in the home. Comments people made to us included, "There are people around to look after you and there's always someone there if you buzz", "The doors are always locked and nobody can get in" and "I'm just content, I don't think about it. This is my home."

We looked at the recruitment records for four staff and noted a thorough recruitment and selection process was in place. This included references from previous employers, identity checks and a Disclosure and Barring Service (DBS) check; the DBS checks help employers make safer recruitment decisions by reducing the risk of unsuitable people working with vulnerable people.

We asked staff about their understanding of procedures in place to safeguard adults at risk of harm. They were able to demonstrate they understood how to protect people from abuse and were clear about the action to take if they witnessed or suspected abusive practice. Staff also told us they would feel confident to use the whistleblowing policy for the service to report any poor practice they observed. They were confident any concerns they raised with the registered manager or the provider would be taken seriously and acted upon.

We looked at how the service managed risk. Environmental risk assessments were in place and there were procedures to be followed in the event of emergencies. Individual risks had been identified in people's care plans and kept under review. Staff told us they had received training on how to keep people safe; this included moving and handling, the use of equipment and infection control.

People's care plans included risk assessments related to their individual and diverse needs and abilities. Care plans explained the equipment and the number of staff needed and the actions staff should take to minimise risks to people's health and wellbeing. All the risk assessments had been reviewed on a regular basis and updated to reflect when people's needs had changed. We noted entries were made in the communication diary to inform staff of any changes made to people's records.

There were policies in the service to protect people from risks of infection. Staff had received training on infection control and prevention and information about the spread of infections was readily available. Our observations showed all staff wore personal protective equipment (PPE) when carrying out care tasks or handling food. We also noted from the records reviewed that staff had sought advice from external infection prevention professional regarding the treatment of a person with a bacterial infection which was easily spread. However, we noted there were no risk assessments on this person's records to advise staff of the correct action to take to help prevent the risk of cross infection. The registered manager confirmed this risk assessment had been put in place prior to the end of the inspection.

We noted the laundry room was also being used to store items including continence pads, toilet rolls and cleaning mops; this presented a risk of cross infection. The registered manager told us they would review these storage arrangements.

Is the service effective?

Our findings

People spoken with during the inspection told us they considered staff were competent and knew how to meet their needs effectively.

We checked the systems in place to help ensure staff were properly trained and supported. The registered manager had a matrix which showed the training staff had completed; this showed not all staff had completed annual refresher training in areas including fire safety, moving and handling and safeguarding adults. The registered manager told us, with the exception of fire safety, all required training was planned. In addition, all staff had been completing a variety of distance learning courses; these included end of life and care planning.

Staff spoken with told us they had received the training they required to keep their skills and knowledge up to date in order to meet people's needs effectively. One staff member told us, "I am up to date with all mandatory training." Another staff member commented, "I have done everything I need. We can always request additional training if we think we need it."

We looked at the systems in place to support staff through supervision and appraisal. These meetings provide an important opportunity for staff to discuss their progress and any learning and development needs they might have. Records we looked at showed staff received regular supervision during which training needs, policies and the needs of people who used the service were discussed. Staff in post for more than one year had also received an appraisal of their performance.

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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that 19 applications for DoLS has been submitted to the relevant local authority and that four of these had been authorised.

We saw that all senior staff had received training in the MCA and DoLS. The registered manager told us it was planned for all staff to undertake this training. Staff spoken with demonstrated an understanding of the principles of the MCA and were able to tell us how they supported people to make their own decisions and choices. Throughout the inspection we observed staff asked people where they wished to sit, eat and what

music they wished to listen to. People who lived in the home confirmed they could follow their own routines and staff respected their choices.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us the food was generally good. Comments people made included, "It could be better, we get the same things. It's cooked well, but I'd like more variety", "It's very good, I enjoy it. Sometimes I have second helpings" and "It's only plain, but it's filling."

We noted there was no chef currently employed in the home. Some members of care staff with appropriate training had taken over the responsibility for cooking meals until a replacement chef could be found. During the inspection we noted, the lunchtime meal was served late on both days which meant some people were sat at tables for extended periods of time. However, everyone told us they enjoyed the food which looked well-presented and appetising.

Records we reviewed showed people's nutritional needs were assessed and monitored. We saw people who required assistance to eat were provided with individual support from staff in a patient and relaxed manner.

We looked at how people were supported with their healthcare needs. We reviewed three people's care plans and noted that they were individualised and included an assessment of each person's particular health needs. Assessments were reviewed on a monthly basis or when there were changes in people's needs. We noted that any changes were recorded within the person's care plan. Care records showed appropriate action had been taken if a person's health condition deteriorated; this included referral to mental health services when people's behaviour or mood was considered to have changed. During the inspection we observed staff contacted GPs and district nurses to request medicines or visits in order to ensure people received effective treatment.

We looked at how people's needs were met by the design and decoration of the home. We saw that people's bedrooms were decorated with personal possessions to help them feel at home in Ravenswing Manor. Aids and adaptations had also been provided to help maintain people's safety, independence and comfort.

Is the service caring?

Our findings

Everyone spoken with during the inspection told us staff were always kind and caring. Comments from people who lived in the home were, "They're very nice and kind" and "They're smashing, very kind." Visitors also commented, "They treat [name of relative] very well. They all know her and try to make her laugh. They're considerate" and "They are very caring, I can't praise the staff enough. One carer stayed beyond her shift to wait for [name of relative] to return from hospital."

We spoke with two visiting health professionals, both of whom gave positive feedback about the caring nature of staff. Both professionals told us Ravenswing Manor was one of the best homes in the area. They commented, "I would be happy to spend my last days here" and "Staff take time and care with people."

Staff told us they considered people received good care in Ravenswing Manor. All the staff spoken with told us they would be happy for a family member to live in the home.

During the inspection we saw that staff were kind, caring and respectful when interacting with people who lived in the home. When we asked people if they were treated with respect by staff, comments people made included "They speak to me like I'm a normal person. If you need help, they'll help you" and "I would soon tell them about it if they didn't."

We reviewed the service user guide which was given to people during the pre-admission assessment. We saw the guide included an 'Equality and Diversity' statement which informed people of the organisation's commitment to a supportive and inclusive environment. The service user guide also stated, "We place the rights of residents at the forefront of our philosophy of care."

We looked at a sample of care records and found staff wrote about people's needs in a respectful manner. Care plans included details about how people wanted their care needs to be met. In addition, there were policies and procedures for staff about caring for people in a dignified and person centred way by recognising the diversity of people's needs. The policy for privacy, dignity and respect referred to equality legislation and advised staff of the need to prevent any discrimination and harassment on the basis of 'protected characteristics' (these include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation) and ensure equitable access to services. We noted staff had also received training in equality and diversity.

Care records we reviewed contained information about people's likes and dislikes as well as recording details about their social history, religious needs and important relationships and interests. This information helps staff to develop caring and meaningful relationships with people. The staff we spoke with demonstrated they had a good understanding of the needs of people who used the service. One staff member told us, "I know people really well. I have been here as long as many of the people who live here."

We observed staff encouraged people to be as independent as possible. For example, one staff member asked a person, "Would you like to go into the lounge? Are you ok to go on your own?" Another staff member

took the time to find a number of different cutlery items in order to encourage a person to eat their meal independently. We noted policies in place directed staff to consider people's well-being as well as how self-esteem could be maintained by encouraging independence.

We saw that care plans and risk assessments had been reviewed on at least a monthly basis or when people's needs changed. Although not everyone we spoke with could recall being involved in care planning, care records we reviewed showed that people who lived in the home, and, where appropriate, their family members, had been involved in care plan reviews. A staff member confirmed, "We sit with the resident and their family when developing care plans. We discuss any changes needed and get feedback from them about the care."

Staff said they made sure information about people was kept locked away so that confidentiality was maintained at all times. We saw that personal documentation including care plans were in a locked cabinet under the desk used by staff in the dining room; this meant they were secure but easily accessible for staff. Medicines records were locked away in the medicine's trolley. This meant that only authorised staff accessed people's records.

During the inspection we asked people about the use of advocacy services. These services provide independent support to help individuals express their views in relation to their care and support needs. No one we spoke with had received information on advocacy services, although the registered manager told us one person was visited regularly by an Independent Mental Capacity Advocate to review their care arrangements which were authorised under DoLS. The registered manager assured us they would arrange for information on local advocacy services to be displayed on the noticeboard.

Is the service responsive?

Our findings

People were complimentary about the staff and their willingness to help them. Comments people made included, "They're very good, if you want help they help you" and "If I want anything I ask my key worker and she'll bring it for me."

We asked staff about their understanding of person centred care. One staff member told us, "It is all about building care plans around the individual's needs." Another staff member commented, "I have worked in other homes and they are not as personal as this one."

Staff completed daily records which documented the care people had received to meet their needs. We noted the records were detailed and people's needs were described in respectful terms. We noted staff completed food and fluid charts, behaviour and positional change charts where there was an identified risk.

We checked whether the provider was following the Accessible information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The registered manager told us they were unaware of this standard but that people's communication needs were always considered as part of the assessment and care planning process. They told us they would check the requirements of the AIS to ensure the service was compliant with them.

Our review of care records confirmed that, where appropriate, people's records contained a communication care plan. These plans and subsequent reviews provided guidance for staff on meeting people's communication needs; for example we noted the monthly review in one person's records advised staff that, "[Name of person] is talking a lot more and can have a conversation with you so take time to talk to her."

We saw that a range of technology was used in the home to improve the care and support people received; this included sensor mats, internet enabled television and an electronic monitoring system for staff to record their hours worked. In addition, the registered manager told us the home utilised an online assessment system called 'Telemedicine' if they had any concerns about people's health. This service was available 24 hours a day and was managed by registered nurses from the local NHS service. Telemedicine provides a remote clinical service between the home and a healthcare provider, using electronic audio and visual means. This helped to provide prompt and appropriate advice and treatment.

We asked about the activities available to people to support their well-being. We were told one member of care staff undertook the main responsibility for planning and organising activities. We noted the registered manager had begun to collate photographs in albums which were on display in the reception area; these provided a record of activities undertaken in the home which included birthday parties and celebrations of events including Halloween and Valentine's Day. The noticeboard included a display of events for the month. We saw that for the month of the inspection these included a sing-along and reminiscence session.

We received mixed feedback when we asked people about the activities provided for them. Most people were satisfied with the range of activities, whereas two people commented they were sometimes bored. Comments people made included, "I watch telly and go out in the garden when it's nice", "I do different things on different days. Sometimes there's activities", "We do knitting. I sit and listen to the radio. If there's anything good on the telly I'll listen to it. I've always been a dancer but I like listening to music. I like quizzes", "There's not a lot to do. I watch the telly. I think television has taken over our lives. Sometimes I get bored, I wish I was at home", "I watch TV and go for a smoke. We have bingo and dominoes, I enjoy those. I don't get bored, there's always something to do". "At times I get bored, I like music but I'd like something to do. I like having a go at anything, I like icing cakes, they don't play games."

When we looked at the log of activities, we noted these showed that approximately one activity per week was taking place. We discussed this with the registered manager who told us this was not an accurate reflection of the activities on offer and that many occurred on an unplanned basis. They told us they would ensure the activity record was fully completed in order to show all the activities provided and the people who had chosen to participate.

We looked at how the service managed complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) and external organisations. However, we noted the policy did not include the names of either the registered manager or director; nor did it detail any contact information such as an address, telephone number or an email address. We discussed this with the registered manager who told us they would ensure the policy was updated to include these details. The complaints policy was also included in the service user guide which was given to people on admission.

We looked at the complaints book and found no record of any complaints having been made. However, we noted from other records reviewed that a relative had raised some issues verbally which had not been documented as a complaint or concern. We discussed this with the registered manager who told us they would ensure all concerns, whether expressed verbally or in writing, were documented in the complaints record.

Although most people spoken with were unaware of the complaints procedure, no one had any complaints about the care and support they received.

Is the service well-led?

Our findings

We looked at the arrangements in place to monitor the quality and safety of the service. We saw that there were a number of audits in place covering infection control, health and safety, care plans and medicines. However, our findings during this inspection showed these audits had not been sufficiently robust to identify some of the shortfalls we detected. These included out of date food in the kitchen fridge and care records which did not always include necessary risk assessments.

We asked about the arrangements for provider monitoring of the service. We were told that the provider paid regular visits to the home, during which they spoke with staff and people who lived in Ravenswing Manor. However, there was no evidence that these visits had been documented to confirm oversight of the quality and safety of the service.

The lack of robust quality assurance processes had led to some of the shortfalls we identified during this inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager for evidence that all accidents and incidents had been recorded, investigated and reviewed for any trends. We were told all accident/incident forms had been archived at the end of 2017; it was therefore impossible for us to review whether appropriate action had been taken and any lessons learned implemented. Following the inspection the registered manager sent us a copy of the analysis of accidents which had occurred in 2017; this showed appropriate action had been taken to help reduce the number of accidents in the future.

People spoken with told us they found the registered manager to be approachable. During the inspection we observed the registered manager was visible and had a pleasant manner with people who lived in the home and staff.

All staff spoken with were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any emergency or concern. There were policies and procedures in place relating to the running of the service; these were aligned to the relevant regulated activities regulations. Staff were made aware of the policies at the time of their induction and most had signed to say they understood their content and the responsibilities placed on them. The registered manager told us they would ensure all staff signed the policies at the end of their induction period and when a policy was updated. We noted supervision sessions held with staff included a discussion of a particular policy each month.

Staff told us they enjoyed working in Ravenswing Manor and that both the registered manager and provider were approachable and supportive. Comments staff made included, "I can go to any staff for support but I particularly like [name of registered manager] and [name of senior carer]" and "[Name of registered manager] is always approachable."

Staff told us regular staff meetings were held at which they were able to discuss any concerns or suggestions

for improving the service. At the inspection we were only able to see records relating to the one meeting held in 2018 as the records of the meetings held in 2017 had been archived. These were sent to us by the provider as requested following the inspection.

We were told formal resident meetings were held regularly. When we asked people who lived in the home about these meetings, some people told us they weren't aware of them taking place. Other people told us they had attended and commented, "We all go and sometimes things change", "I attend regularly, sometimes things change. It's mostly about the food. If somebody said they didn't like something, they'd take it off the menu" and "I only go occasionally; nothing changes." A relative told us they attended the meetings and commented, "They bought some new things, i.e. the minibus."

We looked at the minutes from the most recent meeting but found these were very brief and did not contain an agenda, detailed minutes or actions taken from the last meeting; this meant it was not possible to see if any suggestions or comments made by people had been acted upon. We discussed this with the registered manager who told us more formal notes and record of actions would be made for future meetings.

We were told an annual survey was completed with people who lived in the home, relatives and professional visitors. However, the registered manager told us they only had the summary of responses from the survey completed in 2016. Following the inspection we were sent a copy of the quality assurance report completed in 2017. This showed everyone who participated were either very or quite satisfied with the quality of care provided. The survey included several very positive quotes from people who lived in the home, their relatives and professional visitors. Examples of comments made included, "This is the next best place to home – without exception the staff are very caring", "I can leave [name of relative] in their care and have full peace of mind" and "Having visited several similar establishments, I was impressed with the level of care, welcome by the staff and 'homely environment'. A good example of best practice." We also saw action had been taken as a result of comments made; for example, people had been reminded of the complaints procedure in place in the home

During our inspection our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating in the home, although we found it could be placed in a more visible place in order to inform people of the outcome of our last inspection. We also found the website for the service was under development at the time of the inspection and did not display the most recent inspection rating. Following discussions with the provider after the inspection, we confirmed the new website was now live and the requirement to display the rating on the front page had been met.

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 17 HSCA RA Regulations 2014 Good governance The systems and processes to monitor the quality and safety of the service were not sufficiently robust; this had led to the shortfalls we identified during this inspection.