Ashberry Healthcare Limited

Broomy Hill Nursing Home

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

Summary of findings

Overall summary

The inspection took place on 9, 12 and 23 March 2018. The first day of our inspection visit was unannounced.

Broomy Hill Nursing Home is a 'care home'. People in care homes received 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. Broomy Hill Nursing Home accommodates up to 40 people with dementia-related illness and mental health needs. There were 37 people living at the home when we visited.

There was no registered manager in post during our inspection. We met with the manager who had applied to become registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection of the service on 16 January 2017, we found a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities).Regulations 2014. We gave the service an overall rating of Requires Improvement. This breach related to the ineffectiveness of the provider's quality assurance. The provider sent us an action plan setting out the improvements they intended to make, and we met with them to discuss this further.

At this inspection, we found the provider was still not meeting the requirements of Regulation 17. Their quality assurance systems and procedures had not enabled them to effectively identify and address the shortfalls in quality we identified during our inspection. We also identified a breach of Regulations 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. This related to the provider's failure to assess and take all reasonable steps to reduce the risks associated with people's individual care and support needs.

Infection prevention and control measures at the home needed to be improved to more fully protect people and others from the risk of infection. People's rights under the Mental Capacity Act had not been fully promoted. Staff lacked insight into people's dietary needs. Care plans were not routinely read by staff and were not always updated in response to people's changing needs. A more proactive and consistent approach towards advance care planning was needed.

Staff had training in, and understood, their individual responsibility to protect people from abuse, and the provider had procedures in place to ensure any witnessed or suspected abuse was reported to the appropriate external agencies. Staffing levels at the home ensured people's individual needs could be met safely. The provider completed checks to confirm the suitability of all prospective staff. People received their medicines safely and as prescribed from qualified nurses.

People had support and encouragement to follow a balanced diet, and were involved in choices about what they ate and drank. Any risks associated with people's eating and drinking were assessed. Staff received training and ongoing support to help them succeed in their roles. They defused difficult situations with skill and insight into people's individual needs and personalities. Staff and management helped people to access, a range of healthcare services to ensure their health needs were met. The overall design and adaptation of the premises enabled staff to meet the needs of people living with dementia effectively.

Staff adopted a kind and caring approach towards their work. People and their relatives had support to support to participate in decision-making that affected them and to express their views on the service. Staff treated people with dignity and respect.

People received care and support that reflected their individual needs and preferences. People's relatives were able to contribute towards care planning and care review meetings. People's care plans were individual to them and covered a range of needs. People had access to a range of social and recreational activities, led by the home's activities coordinators. People's relatives knew how to raise any concerns or complaints with the provider.

The management team promoted a positive and inclusive culture within the service, Staff felt well supported and able to request additional support and guidance from the management team. The provider took steps to involve people, their relatives and staff in the service.

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.

The risks to people had not always been appropriately assessed and managed. Staff understood how to recognise and report abuse involving people who lived at the home. People's medicines were safely managed and administered.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments and best-interests decisions had not always been carried out in line with the requirements of the Mental Capacity Act 2005. Staff received induction training to help them settle into their new roles. People had encouragement and any physical assistance required to eat and drink. Staff sought professional medical advice and treatment in response to any significant deterioration in people's health.

Is the service caring?

Requires Improvement

The service was not always caring.

The lack of robust risk assessment and risk management procedures, and failure to fully promote people's rights under Mental Capacity Act 2005 did not reflect a caring approach. Staff treated people with kindness and protected their rights to privacy and dignity. People and their relatives had support to express their views about the care and support provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not routinely read and refer back to people's care plans, in order to ensure a consistent approach towards people care and support. People's relatives knew how to raise concerns about the service and the provider had procedures in place to ensure these were handled fairly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance activities were not as effective as they needed to be. Staff felt well-supported and valued in their work with people. People's relatives benefited from open communication with the management team.

Broomy Hill Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced comprehensive inspection carried out on the 9 March 2018, with further announced visits on the 12 and 23 March 2018.

This inspection team consisted of two inspectors 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 site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority, the local clinical commissioning group (CCG) and Healthwatch for their views on the service. We reviewed the information the provider had 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.

Over the course of our inspection, we spoke with four people who use the service, nine relatives, a local GP and a community mental health nurse. We also spoke with the manager, the provider's quality manager, the clinical lead, a nurse, the head of kitchen, the maintenance person, the housekeeper, two activities coordinators, one senior care staff and three care staff.

We looked at 12 people's care records, medicines records, incident and accident reports, two staff recruitment records, staff training records, complaints records, activities records, and safeguarding records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

The provider had systems and procedures in place designed to ensure the risks associated with people's individual care and support needs were identified, recorded and managed. However, we found these systems and procedures were not as effective or comprehensive as they needed to be. The known or foreseeable risks to individuals had not always been adequately assessed, or the plans for managing these clearly documented.

For example, one person's known sexualised behaviour posed a potential risk of harm to themselves and others. However, a documented risk assessment had not been completed in relation to this behaviour. Furthermore, appropriate specialist advice had not been sought on the management of this behaviour, and there were no documented behaviour guidelines in place for staff to follow. Following our inspection visits, the manager confirmed this person had now been reviewed by an appropriate healthcare professional, and that a care plan had been developed in relation to the management of their sexualised behaviour.

Four other people had been assessed as being at risk, or high risk, of developing pressure sores, one of whom had a current superficial pressure sore. However, there were no documented plans in place to ensure a consistent approach towards maintaining their skin integrity. We found a similar lack of planning in relation to the management of people's challenging behaviour, including resistance to personal care and physical aggression towards others.

Where risk assessments had been undertaken and plans put in place to keep people and others safe, these plans had not always been kept under review to ensure they remained effective. For example, four people's falls risk assessments had not been consistently reviewed in response to recent falls they had suffered.

The manager acknowledged these issues, and recognised the need for improvements to the service's risk assessment and risk management procedures. They assured us the specific concerns shared with them would be addressed as a matter of priority, along with the need for broader changes in how risks to people were assessed, managed and reviewed. Following our inspection visits, the manager confirmed documented risk assessments were in place in relation to people's risk of developing pressures sores and the management of their challenging behaviour.

In the event people were involved in an accident or incident, or any unexplained injuries to people were identified, staff were aware of the need to record and report these events. However, we found the provider's procedures for recording, reporting and monitoring accidents, incidents and unexplained injuries were not as effective as they needed to be. For example, injuries referred to in people's care records had not always been appropriately documented on an accident form. In addition, unexplained injuries to people had not always been clearly recorded, investigated and reported to the manager. Following our inspection visits, the manager confirmed steps had been taken to ensure more consistent monitoring of accidents, incidents and unexplained injuries by the nursing team and themselves.

Infection prevention and control measures at the home needed to be improved. The condition of some

fixtures, fittings and equipment within the home hampered effective cleaning, and so placed people at an increased risk of infection. This included a heavily-rusted hoist, broken pedal bins used for clinical waste disposal and dining room chairs and lap tables that had not been re-varnished or thoroughly cleaned. The manager and quality manager acknowledged these issues, a number of which had been identified through the service's internal monthly infection control audits. They assured us the provider's planned programme of refurbishment would resolve these issues, along with improvements in cleaning protocols within the home. Following our inspection visits, the manager confirmed the rusted hoist was no longer in use.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always assessed and taken all reasonable action to reduce the risks to people's health, safety and welfare, including the prevention and control of infection.

During our inspection visits, we observed a small section of exposed hot water pipework in a corridor on the home's first floor, located just above the skirting board. This was a potential hazard to the people living at the home. The manager, who had not previously identified or been made aware of this hazard, assured us this pipe had previously been covered. During our inspection visits, they arranged for the relevant pipe to be re-clad.

The majority of the relatives we spoke with felt confident their family members were safely cared for at the home. One relative told us, "It's the fact you can go in anytime during the day or night and staff are always there and caring for [person] and know where they are." The provider had taken steps to protect people from abuse, discrimination or any other breaches of their dignity and respect. Staff received training in, and understood, their individual responsibility to remain alert to and report any form of abuse affecting the people who lived at the home. They told us they would report any concerns of this nature to the nurses and manager. The provider had procedures in place to ensure any witnessed or suspected abuse was reported to the appropriate external agencies, such as the local authority, police and CQC, and thoroughly investigated. Our records showed they had previously made notifications to CQC in line with these procedures.

Most relatives, and the staff we spoke with, told us staffing levels at the home ensured people's individual needs could be met safely. One relative explained, "They seem to have been much better staffed for quite a while. There always seem to be plenty of staff when I've been in [to the home]." A member of staff said, "Since [manager] has been here, the staffing levels have completely changed, and it's nice that we can get things done without thinking we won't have time." The manager explained they monitored staffing requirements in line with people's current needs. Staff shortages, including the home's current nurse vacancies, and unplanned staff absences were covered through staff overtime and the use of regular agency nurses.

The provider completed checks on all prospective staff to ensure they were safe to work with people. This included requesting employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions.

The provider had procedures in place to ensure people's medicines were handled and administered safely and in line with current professional guidance. Since our last inspection, they had introduced a new electronic medicines management system to support safe, consistent practice in this area. People received their medicines from trained nurses who maintained up-to-date medicines records. The nurses had access to clear 'PRN protocols' to guide them on the expected use of people's 'as required' medicines.

Requires Improvement

Is the service effective?

Our findings

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

We checked whether the service was working within the principles of the MCA. People's relatives told us, and we saw, staff respected people's decisions, and sought their consent before undertaking their routine care and support. Care staff had an appropriate understanding of the implications of the MCA for their work with people. Do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decisions had been appropriately recorded in people's care files, along with records of the consent obtained to people's care and support.

However, mental capacity assessments and best-interests decision-making had not always been carried out where appropriate. This included the decisions taken to restrict one person's access to alcoholic drinks, milk, and their use of kitchen facilities. Another person's unmonitored access to the home's 'garden lounge' had been removed without evidence of any associated best-interests decision-making.

Where best-interests decisions had been made for people who lacked capacity , these had not always been appropriately reviewed. For example, decisions taken to administer people's medicines covertly had been reviewed by the clinical lead without the involvement of appropriate external healthcare professionals. We saw another best-interest decision prohibiting one person's friend from visiting them at the home had not been reviewed since 2014.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always sought people's consent and acted in accordance with the requirements of the Mental Capacity Act 2005.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the management team had made applications for DoLS authorisations based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, the manager had reviewed any associated conditions, in order to comply with these.

The range of food and drink provided at the home enabled people to have a balanced diet. One person told us, "The food is very good. We always have two main choices [at mealtimes], plus a roast every Sunday." Staff helped people to choose between the options available at each of the day's three main mealtimes, and gave them encouragement and appropriate physical assistance to eat and drink.

Any specific risks associated with people's eating and drinking were assessed, through the use of a

recognised screening tool and with appropriate input from people's GPs and the local speech and language therapy (SLT) team. Plans were in place to manage these risks, including the provision of fortified and texture-modified diets and the monitoring of people's food and fluid intake. The management team held a monthly nutritional meeting with the head chef to review how effectively the service was meeting people's current nutritional needs, and any changes in these. One relative explained, "They [staff] recently had to start mashing food up for [person]; They are on the ball." However, we found care staff lacked clear insight into people's current dietary needs, specifically those people who required fortified diets. The manager assured us they would address this issue without delay.

At our last comprehensive inspection of the service on 16 January 2017, and our focused inspection on 20 July 2017, we found that a significant number of staff had yet to complete the provider's mandatory training. Where staff had participated in this training, appropriate refresher training had not been consistently organised at the required intervals. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was now meeting the requirements of Regulation 18. The management team now had effective oversight of staff training and development needs. Significant effort had been made to bring staff training up to date, and a clear plan was in place to address any outstanding training needs. Some staff questioned the value of the online training they completed. One staff member told us, "I don't rate them [e-learning courses] very much. I'd rather go somewhere and have someone teach me than watch a two-minute video." The manager explained they were moving towards a more 'blended' approach to staff training, and had recently arranged face-to-face training on first aid, falls prevention and the MCA.

One person described staff as, "very patient, and very skilled at what they do". People's relatives were satisfied staff had the skills and knowledge needed to meet their family members' individual needs safely and effectively. One relative told us, "They [staff] seem very competent." We saw a number of instances in which staff approached and defused difficult situations involving people who lived at the home with tact, sensitivity and clear insight into people's personalities.

Upon starting work at the home, new staff completed the provider's 12-week induction training to help them understand and settle into their new roles. This included the opportunity to work alongside more experienced colleagues, and completion of initial training and competency checks. One new starter to us, "They [staff and management] have been brilliant. Any questions I've had, they've always answered and they've shown me what to do daily." Following induction, staff attended bi-monthly one-to-one meetings with a senior colleague to identify any additional support or training needs they may have, and to receive feedback on their performance at work.

Prior to people moving into the home, the management team met with them, their relatives and the community professionals involved in their care to assess their individual needs and requirements. This enabled them to draw up effective care plans to achieve positive outcomes for people and avoid any form of discrimination in the care and support and support provided.

Staff and management liaised with, and helped people to access, a range of community healthcare professionals to ensure their health was monitored and their health needs met. This included GPs, nurse practitioners, specialist consultants and nurses, and the local In-reach team. In the event of any significant change or deterioration in people's health, we saw staff sought professional medical advice and treatment as required. One relative explained, "If [person] needs a doctor, they [staff] see to it and tell me if something's wrong. They are very good."

The overall design and adaptation of the premises enabled staff to meet people's individual needs effectively. People had access to suitable spaces to participate in social activities, meet with visitors or spend time alone if they chose. People had access to dementia-friendly activity resources, such as rummage baskets and sensory or reminiscence items, such as typewriters and kitchen utensils. The manager explained they intended to further adapt the home's environment to the needs of people with dementia through, for example, laying more suitable flooring in some areas.

Requires Improvement

Is the service caring?

Our findings

People and their relatives felt individual staff members adopted a caring attitude towards their work. One person told us, "It [home] is very nice; I like it here. They [staff] are always kind." A relative said, "The girls [staff] are so caring and helpful; I can't fault them." Another relative told us, "They [staff] makes [person's] life a lot happier. They'll take the time to talk to them and sing with them when [person] listens to music." However, the provider's lack of robust risk assessment and risk management procedures, and their failure to fully promote people's right under the Mental Capacity Act 2005 did not reflect a caring approach.

We saw people were at ease in the presence of staff, and that staff greeted and spoke to people in a warm and professional manner. Staff took the time to praise people on their appearance that day, and responded in a prompt manner to anyone in discomfort or distress. For example, upon observing one person had fallen asleep in their chair in an awkward position, staff immediately fetched an extra pillow to adjust their posture.

People's relatives were satisfied with support they and their family members living at the home had to voice their opinions and be involved in decisions that affected them. They described open communication with the service, which ensured they were kept up to date about any changes in their family members' health and wellbeing, and allowed them to have their say at any time. One relative told us, "It [communication] is very good indeed. They [staff] let me know if anything has happened every time I go in, and they phone me up if they need to." We saw people's care plans included information about their individual communication needs and guidance for staff on how to promote effective communication with them. This included guidance on how to support and reassure one person who was registered as blind.

People's relatives were satisfied their family members were treated with dignity and respect at all times. On this subject, one relative told us, "I think they [staff] do the best they can. They always tell [person] what they are doing and ask if it's alright to do this or that." The manager explained they had recently introduced a new e-learning course on dignity and respect for staff, and now undertook monthly 'dignity in dining' audits. We found staff understood their individual responsibilities to protect and promote people's rights to privacy and dignity. They gave us examples of how they did this on a day-to-day basis. This included protecting people's modesty during personal care, offering them choices and respecting their decisions. One staff member explained, "You've to do what you'd want done for your family member." During our inspection visits, we saw staff taking steps to protect people's dignity. This included offering one person patient encouragement and support to change out of their nightwear into daytime clothes following breakfast.

Requires Improvement

Is the service responsive?

Our findings

People's relatives were satisfied their family members living at the home received care and support that reflected their individual needs and preferences. One relative explained how staff encouraged their family member to eat, whilst managing their preference not to sit still in one place. They told us, "What they do really well is involves the fact [person] won't sit down to eat. They [staff] will go and make them a sandwich which [person] can eat as they are walking."

People's relatives felt able to contribute in their care planning and care review meetings. One relative told us, "When [person] first moved there, there was a huge amount of talking about them and asking me questions. They continue to ask me things. A lot of staff ask me about [person's] previous life. It's like they are interested in their past life and not just how they are now. I do feel involved." Another relative explained, "You feel as though they [staff and management] are looking for any information which will assist your [family member]." We saw people's care files included information about their personal histories, interests and known preferences. People's care plans were individual to them and covered a range of topics and needs, including their social needs, mobility, nutrition, health needs and sexuality.

However, although people's care plans were evaluated by the nursing team on a monthly basis, we found they were not always updated in response to people's changing needs. For example, one person's nutritional care plan did not refer to the introduction of a fortified diet following significant weight loss. Another person's mobility care plan did not adequately reflect their current high risk of falls. In addition, staff told us they did not have the opportunity to read people's care plans and, rather, relied upon information gathered from conversations with the nurses and other colleagues about people's individual needs. One staff member explained, "I've never had the chance to read a care plan. You just find out bits as you are going along." This may have affected the consistency of the care people received. Following our inspection visits, the manager confirmed a staff meeting had been held to impress upon all staff they must, and would be given time to, read each person's care plans. They had introduced 'read and sign' sheets to keep track of this process.

People had access to a range of social and recreational activities, developed around their known interests and preferences. These included music therapy, fun exercise classes, aromatherapy, group games, trips out and one-to-one reminiscence work. One relative told us, "[Person] is doing exercises and music therapy twice a week, and they [staff] try and read to him. They are getting individual attention." During our inspection visits, we saw people enjoying, amongst other activities, a music therapy session and one-to-one time with staff. The home's activities coordinators participated in monthly Skype calls with activities coordinators from the provider's others homes and attended local events to gain fresh ideas for new activities which may be of interest or benefit to people at the home.

People's relatives knew how to raise any concerns or complaints about the service if they needed to, by speaking to the nurses or manager. One relative told us, "I've never had to complain, but I would certainly go to [clinical lead] and feel quite confident about going to [manager] as well if I needed to." They went on to say, "You never feel you are being awkward by going to them, but feel they welcome the chance to put it

right." The provider had a complaints procedure in place to promote fair and consistent complaints handling. We looked at the most recent complaint received by the service, and found action had been taken to resolve the complainant's concerns, who had received a written response from the manager.

At the time of inspection visits, no one living at Broomy Hill Nursing Home was receiving palliative or end-of-life care. We saw the provider had procedures in place to identify people's preferences and choices for their end-of-life care through discussion with their relatives. However, we found they needed to adopt a more proactive and consistent approach towards advance care planning. For example, one person's 'death and dying' care plan referred to the management team's unfulfilled intentions to discuss their end-of-life wishes with their relatives as far back as 2012.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection on 16 January 2017, we were not assured that the provider's quality assurance was as effective as it needed to be. It had not enabled the provider to highlight and address, in a timely manner, the significant shortfalls in quality we identified during our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was still not meeting the requirements of Regulation 17. The home's current manager had a clear understanding of, and expressed commitment to, the provider's quality assurance systems and procedures. This consisted of a rolling programme of monthly audits, including those targeted at 'quality and compliance', the management of medicines, health and safety arrangements, catering, hand hygiene practices and falls. We saw evidence of improvements in areas such as the promotion of people's dignity and respect, and staff training provision. However, this was the service's third successive overall rating of 'requires improvement', and the provider's quality assurance had not enabled them to address the concerns we identified during our inspection visits. These included the lack of robust risk assessment and risk management procedures, the failure to fully promote people's rights under the MCA, and staff members' lack of reference to people's care plans.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's quality assurance systems and procedures were still not as effective as they needed to be.

During our inspection visit, we met with the manager who was responsible for the day-to-day management of the service, and who had applied to CQC to become registered manager of the service. They demonstrated a clear understanding of the duties and responsibilities associated with their post, including the need to submit statutory notifications to CQC in line with the provider's registration with us. The service's current CQC rating was clearly displayed at the premises, as the provider is required to do.

The manager felt well supported by the provider and confirmed they had the resources needed to provide safe and high-quality care. They explained that they kept themselves up to date with legislative changes and current best practice guidelines by, for example, participating in further training, the local registered managers' forum meetings, and the provider's weekly Skype meetings for managers.

The management team promoted an inclusive culture within the service, based upon open communication with people, their relatives, community professionals and staff. One person told us, "I like the new manager very much; we get on alright. They make the time to come and chat to me and ask how we are." A relative explained, "They [staff and management] keep me well up to date with everything that's happening and anything that needs special attention."

People's relatives had confidence in the overall management of the service, and spoke positively about their relationship with the management team. One relative told us, "[Home manager] said people's care is the most important thing to them. They seem as though they are out to improve things and I feel quite confident

in them." People's relatives found the management team approachable and willing to listen to their views.

We saw staff were at ease in the presence of the management team, who maintained a visible presence throughout the home. Staff spoke about their roles at Broomy Hill Nursing Home with enthusiasm and felt well-supported in their work. One staff described the manager as "supportive, compassionate and very clear about professional boundaries." Staff felt able to request additional support or guidance from the management team at any time. One staff member explained, "It [management of the service] is getting better. [Manager] listens to you when you have something to say or if you've got a problem." They went on to say, "[Manager] keeps things in confidence, and that means a lot really." Staff had confidence in the management team's willingness and ability to act on issues brought to their attention. For example, one staff member told us, "[Manager] is understanding and, if you have an issues, they sort it out when they say they are going to."

The provider had a whistleblowing policy in place, and staff told us they would follow this, if necessary. Whistleblowing refers to when an employee tells the authorities or the public that the organisation they are working for is doing something immoral or illegal.

The provider took steps to involve, and invite feedback from, people, their relatives and staff. Regular nursing staff and general staff meetings were organised, along with quarterly 'residents and relatives' meetings. In addition, a regular newsletter detailing recent events at the home, and upcoming activities, was distributed to people's relatives and made available to all visitors.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not always sought people's consent and acted in accordance with the requirements of the Mental Capacity Act 2005.

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 had not always assessed and taken all reasonable action to reduce the risks to people's health, safety and welfare, including the prevention and control of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and procedures were not as effective as they needed to be.