Beling & Co Limited

Wensley House Residential Home

Inspection report

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Epping
Essex
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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

Wensley House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 48 people over three floors in an adapted building. There is a passenger lift to provide access to people who have mobility issues and the garden is also accessible. 45 people were living in the service at the time of this inspection, two of whom were in hospital.

A registered manager was not in post. 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.

The service had inconsistent management since the last inspection and the provider managed the service when no manager was in post. An experienced manager was now in post and who had made application to register with CQC as required.

We rated the service as Good at our last inspection on 5 January 2017. We received information of concern in November 2017 that insufficient staff were available in the service. Concerns also related to people's care, communication, fire safety, medicines and the failure of the provider and manager to deal with these effectively. We shared the information with the local authority who visited and were supporting the service to improve. We also received information that recruitment procedures in the service needed improvement.

This inspection was unannounced and completed by two inspectors on 16 and 17 January 2018. We found three breaches of regulation and other areas of practice that needed to improve.

People's individual risk management plans did not support people's safety. Equipment was not safely used. Medicines were not safely managed to ensure people's wellbeing. People's care needs were not planned for in a way that gave staff clear guidance on how to meet these safely and well. This included people's nutritional and social care requirements.

The lack of consistent competent leadership in the service had affected the quality and safety of the care people received. The provider's quality assurance processes were not sufficiently robust as they had not identified the failings in the service so that corrective action could be promptly taken.

Discussion with staff and review records showed that information was not always shared or acted upon so that learning could take place to safeguard people. Records also showed that checks of prospective staff needed to be more thorough and ensure that references obtained were always from the most appropriate

people.

Staff support systems had faltered. Staff had not received continuous training, support and competence assessment to ensure they provided people with safe and effective care. The manager had recently recommenced the provider's systems to supervise staff, monitor their performance and to plan a staff training programme.

While staff generally sought people's consent, improvement was needed to records and staff understanding to show that up to date guidance about protecting people's rights in decision-making was followed.

People told us they enjoyed the meals and drinks served overall although sometimes food was not hot enough. Staff approach to supporting people to have a positive mealtime experience needed to improve in some areas. People told us that staff were kind and caring overall and treated them with respect. We noted occasions where staff did not make efforts to interact and engage people. Visitors felt welcome.

Enough staff were deployed to meet people's needs. Systems were in place to monitor staffing levels in line with people's changing needs and these were positively supported by the provider. Arrangements were in place to support people to gain access to health professionals and services.

Wensley House offered people a clean and comfortable environment that was well-maintained.

People felt able to raise any complaints and felt that the manager and provider would listen to them. Information to help them to make a complaint was readily available. People knew the manager and provider and found them to be friendly and regularly available in the home.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems to manage individual risk to people and to manage people's medicines were not always safe.

Staff did not always recognise and report unsafe practices. Learning from incidents was not used to improve safety.

Systems in place to manage safeguarding concerns needed strengthening.

Recruitment records needed more attention to ensure robust procedures were consistently in place.

There were enough staff to meet people's needs. People lived in an environment where the risk of infection was safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective. □

Staff training and ongoing supervision needed improvement to ensure staff were able to provide people's care safely and well.

Clarity was needed in records regarding people's ability to make decisions and to ensure their rights relating to consent were fully supported.

Improvements were needed so that all people in the service were supported to enjoy the mealtime experience.

People's needs were assessed to identify their care requirements. Peoples' day-to-day healthcare needs were met in a timely way and they had access to health and social care professionals when required.

The design and adaptations of the premises met the needs of the people who lived there.□

Is the service caring?

Requires Improvement

The service was not consistently caring.

While we noted positive interactions, some staff communication with people was limited.

People felt they received a caring service.

People's privacy and dignity was supported overall.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not reliably planned so that staff had guidance to follow to provide people with consistent person centred care. This included when people were receiving end of life care.

Improvements were required to ensure that all people who lived at the service received the opportunity to participate in meaningful activities and social engagement.

People felt able to raise concerns and complaints and were sure they would be listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Management of the service was not stable or effective. The culture allowed a lack of clarity in communication, responsibilities and improvement through learning.

The provider's systems to check the quality and safety of the service were not robust and had not identified shortfalls in the quality of the service.

Wensley House Residential 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.'

Two inspectors completed this unannounced comprehensive inspection on 16 and 17 January 2018.

Prior to the inspection, we had received information of concern regarding the service and so brought our scheduled inspection of the service forward. A Provider Information Response request was therefore not sent prior to this inspection. We looked at information that we had received about the service. This included information we received from the local authority and any notifications from the provider. Statutory notifications include information about important events that the provider is required to send us by law.

During the inspection process, we spoke with eight people who received a service and three visitors. 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. We also spoke with the manager, the provider and seven staff working in the service.

We looked at 12 people's care records and 14 people's medicines records. We looked at records relating to eight staff. We also looked at the provider's arrangements for supporting staff, managing complaints and monitoring and assessing the quality of the services provided at the home.

Requires Improvement

Is the service safe?

Our findings

People did not receive a consistently safe care. Staff were not always aware of people's individual risks and how to help people in a safe way. A staff member assisted a person to transfer from a dining chair to a wheelchair by lifting the person under the arms. This unsafe practice could result in injury to the person. The person's facial expression indicated clear discomfort with this manoeuvre. The person was unable to tell us verbally about this experience.

Assessment of risk to show staff how to keep people safe was not in place. One person was at high risk of choking when eating or drinking. There was no risk assessment relating to this to instruct staff on how to limit the risk and maintain the person's safety. One person required oxygen therapy via an oxygen concentrator and portable oxygen. The manager told us the person could self-administer their oxygen. There was no risk assessment to measure the person's ability to do so correctly and safely.

Equipment was not used in a way that kept people safe. We saw unfixed and uncovered bedrails in use on a person's bed. The manager told us staff should not be using these for the person, as it was not safe. This contradicted the information in the person's care records. The manager removed the bedrails immediately. Bedrails used to prevent people falling out of bed are not suitable for everyone so a detailed and accurate risk assessment is needed. People may try to climb over the bedrails and sustain serious injury. Bedrails also need to fit the bed securely.

Risk assessments were not updated when incidents showed this as needed to support people's safety. Records stated that staff recently found another person sitting with their legs over the bedrails, which had come away from the bed. A staff member told us that another person had recently climbed over the bedrails fitted on their bed. People's recently evaluated risk assessment did not reflect these incidents. While there was no recorded injury to the people from these incidents, this placed people at serious risk of harm from entrapment injury.

Medication was not safely or competently managed. On the first day of inspection, the medicines administration record [MAR] recorded that all of the people received their prescribed medicines at 08:00. However, we saw people receiving their medicines up to 11.35am, when the morning medication round finished. The next medication round started within two hours. This meant people were at risk of receiving their medicines too close together and potential overdose. There were gaps in four of the 12 people's MAR we looked at. We could not be sure if this was a recording error and if the person had received their prescribed medicine, ointment or eye drops when they should have. Safe storage was not available to people who managed their own medication. This meant that people were at risk of taking medicines not prescribed for them. The provider had not assessed these risks. An external audit of June 2017 identified that the storage for controlled drugs did not meet safety standards. Suitable action had not been taken to address this.

The provider's records showed that seven staff were designated as responsible to administer medicines. Evidence of medication training was available for only four of these seven staff. An assessment of

competence in safe medicines management was available for only one of the staff members involved. None of the staff had completed training on the use of oxygen. Administration of oxygen is a specialised technique and only trained people should support the person with their oxygen therapy and check the equipment to ensure it is in good working order.

Arrangements for reporting and investigating incidents and events when things go wrong were not suitable. Staff had not understood the potential risk and had not reported the incidents with the bedrails to the manager. Records showed the provider planned to routinely supervise and assess a staff member's medication competence following concerns from a medication audit of April 2017. Records to confirm this action were not available. This meant the provider had not used that learning and implemented steps to improve people's safety.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding systems to identify and protect people from the risk of abuse were not consistently robust. Staff had received training, but their knowledge and understanding on how to safeguard people from abuse varied. Most staff clearly knew how to recognise abuse in a care setting and the actions required to report it and to protect people. Other staff could not demonstrate understanding of their responsibilities in this area, which placed people at potential risk. A medication audit of June 2017 found that some people had received an incorrect dosage of, or none of, their prescribed medicines for four days. There were also discrepancies relating to controlled drugs. The current manager told us they believed a safeguarding alert was raised by the manager in post at the time with the local safeguarding authority and the Care Quality Commission [CQC] notified. They could show no evidence of this. CQC did not receive a notification regarding this matter. The current manager demonstrated they knew how to safeguard people. They told us that safeguarding policies and procedures were scheduled for discussion with staff at the next team meeting to refresh staff knowledge.

Recruitment practice needed improvement. Information about prospective staff included their employment history, evidence of identity and criminal records checks as required. Staff ability to communicate clearly in the English language at the time of recruitment is an area for improvement. References were available on all files. Three files did not include a reference from the person's most recent employer in a care environment, where this was relevant, to show the staff member's conduct in that setting. The provider told us they took responsibility for this error. They and the manager confirmed that this would be actioned immediately and for all future staff recruitment.

Infection control practices promoted people's safety overall. A senior staff member picked up a person's tablet that had dropped onto a cabinet. The staff member handled the tablet without gloves on and then gave it to the person. Otherwise, staff used personal protective equipment [PPE] in practice throughout the inspection to protect people from the risk of infection. Staff had access to ample supplies of PPE such as disposable gloves and aprons. Cleaning schedules were in place. The premises were clean. Laundry practices supported safe infection management.

Sufficient numbers of staff were available to meet people's needs safely. People told us that staff were available when they needed or called them. Our observations during the inspection concurred with this. One person said, "Staff do attend in a timely manner." The manager had completed an assessment of people's dependency needs to inform the staffing levels required. The manager confirmed they would now also include an analysis of falls and other safety incidents into this. The manager told us that the provider had agreed to increase staffing levels to improve people's care experience and safety. This would also enable a

staff member to be a designated senior in charge during the night. Recruitment to support this was ongoing. Staff reported that staffing levels enabled them to meet people's needs safely.

People told us they felt safe living at Wensley House. One person said, "I have no concerns for my safety here."

The manager had introduced additional fire safety checks. Inspection certificates were provided to show that that equipment such as emergency fire systems and the passenger lift were safe.

Requires Improvement

Is the service effective?

Our findings

The provider's system for staff induction, training, supervision and appraisal had not been consistently implemented since our last inspection. Staff had received a basic induction within the service. This included working alongside an established staff member. Formal induction to an industry recognised standard such as the Care Certificate was not offered where a staff member had no previous experience in providing care. The manager said they will action this immediately.

The manager had completed a recent review of evidenced training from staff files to enable them to plan additional training. The record showed gaps in staff training in many areas, including medication, health and safety and dementia awareness. The manager, provider and a senior staff member had completed training recently to enable them to provide moving and handling training to other staff. The local authority had identified a need and very recently provided staff with training on care planning. Staff practice and communication showed a lack of skill and understanding in some areas. The provider could not demonstrate that all staff, including agency staff, had received training relevant to their role. The manager confirmed that training was planned in several areas, including dementia awareness, health and safety, food and nutrition, infection control and safeguarding.

Formal and observational staff supervision and appraisal had not been consistently provided while a manager was not in post. This meant that the provider's opportunity to consider and support staff skills, training and development needs was lacking. The new manager had recommenced and completed formal supervision with some staff. The manager told us this had been a challenge in some cases, as staff ability to effectively communicate in the English language needed support. The manager confirmed they will implement the provider's system for staff training, supervision and subsequent appraisal to assess staff competence and support staff development.

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 helped to do so when needed. When people 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that staff generally sought people's consent for day to day activities. We could not determine if all staff had received training in understanding their roles and responsibilities in relation to the MCA. Records needed improvement. The provider had not properly assessed some people's mental capacity or demonstrated clearly that decisions made were in people's best interests. This included for restrictions such as the use of bedrails or pressure mats that alerted staff if a person stood up. This meant the service was not consistently working within the principles of the MCA. One person's records firstly told us they did not have capacity to make decisions and then that they did. Inconsistent records to guide staff meant people's rights may not always be respected. The manager confirmed this area needed improvement. They had completed

and submitted 11 applications for DoLS authorisations to the local authority since being in post.

Most people's care plans identified their nutritional risk levels. This information was not always used most effectively to support good nutritional and hydration. Some people's records showed advice from professional dietician and nutritional referral was not carried over into people's plan of care to guide staff. We observed that one person did not eat or drink much for a number of hours. Fluid and nutrition intake records confirmed this. Nutritional assessment showed the person as at high risk since December 2017 and they had lost weight. We informed the manager, who instructed staff to offer food and drink and who took immediate steps to refer the person to the dietician.

People's dining and hydration experiences varied. One person said, "The food is very edible, I cannot grumble." Another person said, "Often the meals are lukewarm". Staff gave only some people a choice of drinks or information as to what food was on their plate. One staff member sporadically stood over a person to spoon food into the person's mouth. Encouragement and interaction was limited. Some people told us the food was not hot enough. We made the manager aware of these observations and they confirmed they would discuss it with staff immediately to improve staff practice. The food served was plentiful and pleasantly presented. Staff offered sauces and condiments separately to meet people's individual tastes and preferences.

Preadmission assessments were completed. People told us assessment of their individual needs took place before they came to live at the service and they or their relative took part in this. This informed the provider of peoples' needs and wishes so the provider could arrange to meet all aspects of people's diverse requirements. People and their relatives had opportunity to visit Wensley House to help inform their decision-making about living there.

The service monitored people's healthcare needs. People had access to routine healthcare services including GP's, district nurses and chiropody services in order to maintain good health. The manager worked collaboratively with other professionals, including in assisting people to transition from another service. A survey comment from a relative in November 2017 stated, 'As a family we are always notified of anything regarding [person's] health.'

The premises were suitably adapted to meet people's needs for independence, safety and comfort. There was sufficient space in the dining room as not all the people chose to eat there. All bedrooms had ensuite facilities. People told us they had been able to bring in some furniture pieces of their own to make their bedroom more homely and personal. People's bedrooms contained personal items that were important to them including photographs and pictures of family members. The provider had an established and effective programme of redecoration and routine furniture replacement. The premises was well decorated and fittings were in good condition. The provider employed a designated member of staff to ensure any maintenance issues were promptly dealt with.

Requires Improvement

Is the service caring?

Our findings

We had received information of concern that staff often spoke in front of people in another language. This would not show respect people for living in the service. The manager confirmed this had occurred and been addressed with staff. We did not hear staff speak in another language during our inspection. People told us staff treated them with respect, care and kindness overall. One person said, "The majority of staff are nice and kind." Another person told us, "Most staff are fine. Some staff can seem keen to finish tasks and not chat." People told us that their privacy and dignity was promoted and they felt respected in the service. People and staff told us that staff always knocked on doors before entering people's rooms and staff took care to close doors and curtains during personal care.

The ability of some staff to communicate with people or with us was weak as English was not their first language. People may not be understood or understand staff in this situation and people's needs and wishes may not be met in the way they wish. This may also potentially limit the development of friendly, caring relationships. Some staff missed opportunity for contact with people to offer them social stimulation. A staff member took time out to lean on the back of a chair and listen to our discussion with another staff member. A number of people were sitting in the lounge areas without any activity or social interaction. The staff member did not use the time to communicate with people. The staff member did not demonstrate an understanding of the inappropriateness of their action when we discussed it with them. We were unsure if the staff member actually understood what we were asking them due to their limited command of English.

The care we observed was task based at times and needed some improvement. Conversations were often linked to routine activities, however there were some friendly and caring exchanges between staff and people using the service. Staff asked people at lunchtime if they had finished their meal and waited for people to answer. Staff also asked people if they had enjoyed their meal. Staff, including ancillary staff, spoke with people about their visitors and family members, showing a clear knowledge of those who mattered in people's lives. Although these were positive observations there were at times contrasting incidents. Two people asked for drinks; staff continued with tasks and did not provide these until people asked again some 15 minutes later. At other times when staff did attempt to engage, their interactions were not always person centred. One staff member asked a person about music and film from an era that the person clearly did not know about, thus limiting the person's opportunity to join in.

People and their visitors told us that visitors were welcomed in the service. The provider had imposed a restriction on visiting during mealtimes unless there were special circumstances. The manager told us that it was not comfortable for people living in the service to have other people's visitors sitting with them when they had their meals. A separate area was available for visitors to sit in during mealtimes should they prefer to wait. This was discussed in a meeting for residents and relatives. A relative confirmed that they could remain at mealtimes to support their relative and the approach was sympathetic and flexible.

Requires Improvement

Is the service responsive?

Our findings

People's care was not always planned for as required. Three people living in the service did not have a care plan in place despite living in the service for several weeks. This meant staff did not have information on these people's individual needs and guidance on how to respond to them in a way that suited the person. A staff member said, "I read the care plans to know about people and what they need. I do not know about [person], why [they] are here, what [they] need." This related to a person for whom no care plan was in place.

Available care plans did not clearly include all of people's needs and this could affect the effective delivery of their care. One person had a pressure ulcer acquired in hospital. There was no body map to identify the site of the ulcer and no information in the care records on how it was to be treated. Another person's care plan did not include guidance from a health professional relating to a person's high risk of malnutrition. There was limited or no guidance on how staff were to support people's oral care in many of the care plans looked at. Records showed poor oral care as part of a concern raised recently by a relative. Another person had a health condition that caused breathing difficulties. This was not identified in their care plan so that staff knew how to support the person. We saw a person knock their medicines out of a staff member's hands. The person's care plan did not reference their refusal of medication and what action should be taken if this occurred. People identified as at end of life were not supported by a plan of care to ensure their wishes and needs were known and prepared for. No plan was in place for working with the palliative care team and ensuring that pain relieving medication was available to enable people to have a comfortable and dignified death that respected any specific religious needs.

Care plan reviews were irregular. One person could refuse to eat and drink. Encouragement and small portions were to be offered and a target weight of 49 kilos set. The person's current weight was 35.35 kilos. This plan was last evaluated in September 2017, so had not reconsidered if the person was still receiving the most effective care. Another person's care plan, also last evaluated in July 2017, stated that person's medicines were to be crushed and mixed in a drink. The senior care worker told us this was inaccurate as the GP had advised not to do this. We could not be sure that all other staff who had worked in the service were aware of and so had followed the GP's advice. Inaccurate care records put people at risk of receiving inappropriate care.

People's social care needs and interests were not always recorded. There was limited evidence that people were involved in their care planning. The person designated to provide social activities for people told us they kept mental notes on what people liked and how they had reached those conclusions. One person told us they did not take part in activities as those available were not suitable for them. Daily care notes lacked detail on how people spent their day and if they took part in any social activities. This meant that provider and the manager would not know whether people had been supported to meet their aspirations and had received their care as required.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system in place to manage complaints and show clear investigation and response. The manager told us they had received no complaints about the service while they had been in post. Records showed receipt and prompt response to a verbal complaint received since our last inspection. Information on how to make a complaint was openly displayed in the service. A comments and suggestions box was also available so people could express their views anonymously any time if they wished.

People told us they felt able to express their views about the service and had no complaints. One person said, "If I was unhappy with anything I would speak to my family or to [name of manager]."

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well-led. There had been instability in management since our last inspection. The registered manager had left in January 2017. 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. A subsequently appointed manager, the established deputy manager and senior care staff also left the service since our last inspection. The provider had told us they would manage the service while no manager was in post.

The provider had admitted a significant number of people to the service in a short time frame. While a new manager was in post, these admissions took place during a period where there was not established leadership in the service. In addition, there was an identified lack of senior staff in post. This potentially placed additional pressure on the service such as completing care plans and risk assessments in a timely way.

Robust governance arrangements were not in place to regularly review systems and identify risks to people. Care plan audits were not completed as regularly as required. The shortfalls we found in relation to people's care records and risk assessments were therefore not being identified in a timely manner. The provider had delegated the task of writing care plans to senior staff and allocated additional time on the rota for this work. Senior staff and the rota confirmed this. Senior staff told us the time allocated was not enough to allow them to complete the work.

The provider had not been using their own staff support and training systems effectively. Inexperienced staff and those with other needs, such as a poor command of English, had not received additional training and development. The lack of timely supervision and competency assessments indicated opportunities for discussion with staff and identification of weaknesses in the service were missed. This meant the provider did not ensure staff were enabled to identify and provide people with safe, quality care at all times.

The provider had not ensured that staff they left in charge of the service were competent to manage incidents safely and communicate people's needs accurately to other professionals. A staff member told us, "I have nothing to do with care plans. One person had a fall the other night and went to hospital. I looked at that file with the senior for information. The senior wanted me to speak on the phone as their English was not too good." This lack of fluency could result in inaccurate information being received or relayed about people and impact on the care and treatment they received.

Communication, as well as clarity of roles and responsibilities in the service and the management team was weak. The provider and the manager were unaware that some people had no care plan in place and that reviews of other care plans were not completed. Information sharing systems had failed. Staff were not given full information through care plans about the people they were to provide care to. Senior staff had not reported to the manager or provider when they were unable to manage the tasks allocated to them. Care staff had not reported serious incidents. We made the manager and provider aware of incidents identified

thorough our review of records.

Information had not been used to improve outcomes for people. Falls and incident analysis had not been completed to improve safety for people and to better inform the assessment of staffing levels. People's views, gathered through surveys had not been evaluated to see if any improvements were required. This placed people at risk of receiving unsafe or ineffective care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had applied for registration with the Commission as required and this was progressing. The manager had experience in managing care homes. They identified that communication as well as clarity of relationships and responsibilities were the greatest challenge of their role in managing this service. They were able to give examples of positive changes made in the service working with the provider. This included changes to the rota to improve work life balance and staff morale and plans to complete care records alongside the senior staff. The manager confirmed that their regular meetings with the provider would be recorded in future. The manager had joined a local forum with health colleagues and other care home managers to consider issues such as discharges from hospital care and how improvements can be made and as a support system.

People told us that they found the new manager very available and easy to talk to. One person said, "The manager is very nice and very approachable." We saw people chat with the manager freely and noted that the manager knew people's needs well. Staff were complimentary about the new manager and their positive impact on the service. Comments included, "The new manager is lovely, easy to talk to, very approachable and you know you will always get a straight answer. The manager is always there and there is open communication. I do feel supported." Another staff member said, "Things have improved since [manager] has been here. A manager you can talk to and who really listens if you need help– morale is up. [Manager's name] seems a strong manager who will act." People and staff told us the provider was also regularly in the service and always took time to speak with and listen to them.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not assessed people's care and support needs robustly and included all of their needs and guidance on how these are to be delivered and met by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks of inappropriate care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not operated effective systems to protect people against the risks of inappropriate or unsafe care as robust arrangements were not in place to assess, monitor and improve the quality of the service provided.