Manor Court Healthcare Limited

Anson Court Residential Home

Inspection report

Harden Road
Bloxwich
Walsall
West Midlands
WS3 1BT

Tel: 01922409444

Date of inspection visit:
16 November 2021
18 November 2021

Date of publication:
14 February 2022

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Anson Court Residential Home is a residential care home providing personal care for up to 33 people across two floors. At the time of the inspection the service was accommodating 25 people, some of whom were aged over 65 and living with dementia.

People's experience of using this service and what we found
Most relatives and all people we spoke with gave positive feedback about the staff and the home. However, we found shortfalls throughout the inspection which impacted on the safety and quality of care for people.

The quality assurance checks in place to drive improvement were not robust. The provider had not ensured the maintenance and upkeep of the home environment and safety of care was sufficiently monitored. At our last five inspections, we have had continuous concerns the governance systems were not effective to ensure the delivery and monitoring the quality of the service. This has continued to be a concern at this inspection and the provider had not taken enough action to make improvements.

Risks associated with people's health had been identified. However, there was inconsistent information in people's care plans for staff to follow to support people living with diabetes safely.

The home had adequate processes in place to monitor infection control. Staff had access to an adequate supply of personal protective equipment (PPE). However, we found some staff did not always wear their face coverings in line with government guidance. Checks to monitor the cleanliness of carpets and furnishings required improvement.

Medicines were administered safely, although the auditing of medicines that required additional checks required some improvement.

Incidents and accidents were being recorded on a regular basis. However, there was no analysis of the data that would help to identify for trends to support the implementation of improvements to mitigate the risk of reoccurrences.

Care plans had not been consistently reviewed to ensure all the information reflected people's needs. However, the new manager had started to review all care plans and make referrals to health care agencies for some people to have their needs reassessed.

Staff confirmed they had received training to support them in their role. Although some staff had not always followed their infection control training in relation to the wearing of face coverings. Most staff had completed their training through a virtual and on-line programme.

The home environment was not dementia friendly. Repairs to parts of the home had not been completed.

People and most of the relatives felt people were treated with dignity and respect. Although we observed occasions when this was not always the case. We saw kind and caring interactions between people and staff, however we also observed people were left for long periods of time with little or no stimulation or staff engagement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were being supported to get up very early in the mornings and it could not be evidenced this was always by choice.

There were processes in place to safeguard people from abuse. Appropriate recruitment procedures ensured new staff were assessed as suitable to work in the home. The overall dining experience for people was a calm experience. People's dietary needs were appropriately assessed. The service worked with other health and social care agencies to monitor people's health and wellbeing.

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

Rating at last inspection: The last rating for this service was requires improvement (published 05 November 2020) and was in breach of regulations. The provider had completed monthly reports after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last five consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led key question sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Anson Court Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people not always receiving personalised care, some poor

infection control practices and inadequate governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was well-led.

Details are in our well-led findings below.

Anson Court Residential Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team comprised of three inspectors on 16 November 2021. One inspector returned to the home and an Expert by Experience telephoned relatives, to gain their feedback, on the 18 November 2021. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service
Anson Court Residential Home 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 service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information on the Healthwatch website. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with eight members of staff including the provider, nominated individual, deputy manager and manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not assured the provider was consistently promoting good hygiene practices in the home. For example, on entering the home, on the first day of the inspection, there was a strong smell of urine. We found the main ground floor lounge carpet was the source of the odour. We raised our concern with the manager who confirmed they had noticed the odour. We raised the issue directly with the provider and action was taken later that day to clean the carpet. We also found clinical waste bags from the first floor were carried through the home to the ground floor rather than being disposed of in the first floor sluice. This put people at risk of potential cross infection.
- We were somewhat assured staff were using PPE effectively and safely. For example, three staff were found not wearing face coverings in line with government guidance. One staff member told us they were exempt but had not provided any evidence to the manager to confirm this. This would have enabled alternative protective equipment to have been considered. The remaining two staff had no exemption from wearing face coverings. No risk assessments for any staff, including those with a medical condition, had been completed for COVID-19. This meant people had been put at risk of potential viral infection and no consideration had been given to staff members to mitigate the risk of cross infection.

We found no evidence people had been harmed, however, infection control practices within the service required improvement and was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were somewhat assured that the provider was supporting people to use and access their environment safely. The layout of the home did not always support people to maintain safe social distancing.
- We were somewhat assured that the provider's infection prevention and control policy was up to date.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Assessing risk, safety monitoring and management

- At the last inspection we identified window restrictors did not restrict all windows from opening 100mm or

less in line with the Health and Safety Executive (HSE) guidance (Falls from windows and balconies in health and social care HSIS5 (hse.gov.uk). The provider informed us after the last inspection the restrictors had been replaced. At this inspection we found this was not the case and window restrictors had not restricted openings to 100mm or less. In addition, we identified a window leading into a visiting area had no restrictors in place at all. This posed a potential risk to people who may try to leave the home or climb through the window into the visiting area, which may or may not be kept secured at all times.

● At the last inspection we identified improvement was required when assessing health risks to people. Although there had been some improvement, we found risks associated with diabetes had not been consistently recorded in people's care plans. This meant staff were not provided with clear guidance on how to support people living with diabetes in a consistent and safe way.

● The fire risk assessment for the home had expired in January 2020. Health and safety checks had been completed but not by a qualified fire safety expert. Damaged door seals around two fire doors and a hole in a bedroom door had not been identified. This meant the doors did not meet the British Safety Standards and had the potential to reduce the effectiveness of the doors fire resistance.

● Fire-fighting equipment had been checked. Regular fire alarm testing was completed on a weekly basis. People had personal emergency evacuation plans in place and staff knew what action to take in the event of an emergency.

● Risk assessments were in place for people at risk of losing weight, poor skin integrity and their mobility. Staff we spoke with knew people's needs.

Learning lessons when things go wrong

● Incidents and accidents were recorded, however there was no analysis to identify for trends and implement action plans to mitigate against future reoccurrences.

Staffing and recruitment

● There were a mixture of opinions around staffing levels. One staff member told us, "I know the seniors have raised it (staffing levels) with the manager and we haven't heard anything yet; it can be a bit stressful at times (low staffing levels)." Another staff member said, "I think we have enough staff at the moment and the manager is trying to recruit." A relative said, "There doesn't seem to be enough staff. When I arrive and I am ringing the bell they can see me waiting but walk on by." Our observations during the two days at the home found staff were busy. They did not have time to sit and engage in meaningful conversation or activities with people. However, we found there were enough staff on duty to meet people's identified support needs.

● We raised our concerns about staff numbers on duty at night. The provider explained they based their staffing levels on the number of people living at the home but did not consider people's individual support needs. This meant the provider did not use their dependency tool effectively to determine the number of staff required.

● There were recruitment checks in place to make sure staff were safely recruited.

● Recruitment checks included confirming the applicant's vaccination status as a condition of working at the home.

Using medicines safely

● The checks on medication that required additional monitoring required some improvement to make sure they were disposed of promptly when no longer required.

● Protocols were in place for medicines prescribed for people on an 'as required' basis.

● Staff competencies to administer medicines had been assessed.

● Medicines were being safely stored.

Systems and processes to safeguard people from the risk of abuse

● At the last inspection improvement was required to the reporting of safeguarding incidents. At this inspection we found there had been improvements made. Safeguarding incidents were recorded and showed referrals had been made to the local authority safeguarding team.
● Staff were aware of their legal responsibilities to keep people safe from risk of abuse. They knew how and who to report concerns to.
● People and relatives we spoke with told us they felt the home was a safe environment for people to live in. One person said, "I feel safe and happy here (at the home)."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. At the last inspection when this key question was reviewed in October 2019, it was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- At the October 2019 inspection we found improvement was required to the decoration of the home to make the environment more accessible for people living with dementia. We found at this inspection some improvement was still required.
- Some areas of the home still required redecoration and refurbishment. The environment did not promote independence for people living with dementia. For example, all bedroom doors were painted the same colour and did not help people to recognise their own bedroom.
- The main lounge had been set up with all the chairs placed around the room against the walls. This made conversation for people difficult and we saw some people were sitting at an angle on the edge of their chairs to speak to the person next to them. This increased the risk of the person falling from their chair. This was discussed with the deputy manager and manager.
- There were suitable visiting areas available for people to meet their loved ones in a safe and private environment.
- People had access to a private, secure garden area.

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

- One person's cultural needs had not always been taken into consideration when planning their meals. Kitchen staff told us a list of preferred food and ingredients had been provided by the person's family, but this was no longer available for staff to refer to. We raised this with the manager and they immediately took action to make sure the person's cultural, dietary needs were considered and measures put in place to support a more person-centred diet.
- There were no easy-read or picture accessible menus for people to see what choices were available for their daily meals.
- We saw the mealtime experience was positive for people with a relaxed atmosphere and people appeared to enjoy their food.
- People were provided with lots of drinks throughout the day and supported with these by staff when needed.
- Where people had their weight monitored due to weight loss, their diet was enhanced with high calorie food such as cream, butter and regular snacks.

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

- People's needs had been assessed prior to them moving into the home. These assessments considered people's medical history and current care needs. Assessments showed some consideration had been given

to any protected characteristics under the Equality Act, such as Religion.

Staff support: induction, training, skills and experience
● People and most relatives told us they felt staff had the skills to support people. One relative said, "Staff are very good because [person] is quite deaf. I have no criticism of the care they (staff) are offering."
● Staff told us they had continued with their training which had been completed virtually and on-line during the COVID-19 pandemic. Some of the staff told us they were looking forward to receiving face to face training which the manager was in the process of arranging.
● Records looked at showed staff had received training updates where needed and had their competency assessed to ensure they were applying their learning in practice. Overall, we found staff followed the training and guidance provided to them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We saw evidence to support people had access to healthcare services when needed. Records showed people had been seen by health professionals such as visiting nursing staff and GP.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Where there were concerns over people's capacity, mental capacity assessments had been completed.
● Where DoLS authorisations had been granted, they were being reviewed and processes were in place to submit new applications when expired.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection when this key question was reviewed in October 2019, it was rated as requires improvement. At this inspection this key question has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Although people and most relatives told us they felt they were treated with dignity, we saw instances when this was not the case.
- One person was known to go into other people's bedrooms and sleep in their beds, when the bed was empty during the daytime. We spoke with three staff members who confirmed this was a regular occurrence and it was accepted by staff as a routine, day to day happening. No consideration had been given to the people whose beds were being slept in, or the potential impact of cross infection in the event of any future outbreak of COVID-19 or any other infectious virus. This was not dignified for the person nor was it dignified practice for those whose bedroom the person had slept in.
- On the second day of inspection we found 12 people were already up and dressed at 7am, sitting at tables in the dining area. Two people we spoke with told us they did not mind getting up early. However, the remaining people were unable to tell us if this was their preferred? choice. Care plans did not clearly indicate who wanted to be up early. We saw those people who had the mental capacity and ability to instruct staff they wished to remain in bed, were left until they chose when they wanted to get up. Two staff told us there was an expectation on them to 'get' as many people up as possible before the day shift arrived. This was not a caring or person-centred culture.

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

- People who could tell us and some of the relatives confirmed they had been involved in decisions about people's care. Staff we spoke with demonstrated in their answers how they supported people to make choices. One staff member told us, "I will ask people what they would like to drink and offer them different choices like a tea or if they prefer juice or water."

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

- People and relatives spoke positively about staff and told us staff were kind and caring. Comments made included, "They are good girls to me," and, "The staff are excellent."
- We saw caring interactions between staff and people. Staff spoke in a compassionate way about people and it was clear they cared about people's well-being.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection when this key question was reviewed in October 2019, it was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person-centred care.
- Peoples' care files were disorganised and some care records had not been reviewed. However, the provider had introduced a new electronic system and the manager was in the process of reviewing care plans and transferring paper records to the electronic system.
- The care plan for one person, which stated the person had specific cultural requirements, had not being routinely adhered to.
- Staff had been instructed to ask people, who had the ability to look after their own personal care needs, whether they had opened their bowels each time the person went to the bathroom. There was no medical reason why staff would need to know or ask this question and indicated a task-based approach to monitoring people's personal care as opposed to a person-centred approach which afforded people dignity.

- Peoples' care records had not considered whether people wanted to get up or go to bed early. This meant there was a risk people were being assisted to get up at a time in the morning that was convenient for staff and not centred on the specific requirements of the person.
- Two relatives said some of their family member's clothes, which were labelled, had gone missing and on occasions they had visited had found their family member in someone else's clothes.
- People's social care needs were not being met.
- On the first day of inspection a staff member came into the main lounge area and without asking the people watching the television, changed the channel without any regard for people's preferences.
- There was a planned, weekly, activity programme displayed in the corridor. However, we saw people were left sitting for long periods of time without any stimulation or interaction from staff.
- Some staff took time to chat with people. Yet we also observed people were walking around the home, confused about where they were and with little or nothing to occupy their time or engage them in meaningful interactions.
- One relative told us, "They [staff] don't know where [person] is in the building when I arrive. This upsets me as I always tell them in advance the date and time I am arriving. Sometimes I have to go and find [person] in the building and I don't think this is right."

We found no evidence people had been harmed. However, people were not consistently receiving person-centred care and this was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to keep in touch with family and friends. This included pre-arranged visits to the home.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● No communication aids were used to help people chose food and drink such as pictures of food or showing people different plates of food to help them decide.
● People's care records showed there had been some consideration given to people's communication needs.

Improving care quality in response to complaints or concerns
● Although there had been no complaints raised with the provider, there was a complaints process in place that would investigate concerns if they were to arise.
● Relatives told us if they had any concerns they felt comfortable to raise these with the manager.

End of life care and support
● The manager told us no one was currently receiving end of life care.
● There was information in people's care records to show discussions had taken place with some people and relatives about their wishes and preferences in respect of end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- At the last five inspections, we have rated well-led as requires improvement or inadequate. We have taken enforcement action through imposing conditions on the provider's registration to drive the changes needed. However, the provider had failed to make the necessary improvements. They had not met the conditions imposed on them to make improvements to monitor the safety and quality of the care being delivered to people.
- Significant shortfalls were identified at this inspection. There were breaches in relation to safe care and treatment, person-centred care and governance. These issues had not been identified or addressed through the provider's own governance systems.
- There was a lack of consistent and effective management and leadership. There had been different managers at the home since the last inspection and no registered manager since October 2019. A new manager was in post when we inspected, with an intention to register with CQC as the registered manager. Staff said the manager was fair and approachable and keen to make improvements.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. There were no provider visit reports or checks to ensure compliance with regulations.
- There were no robust systems in place to ensure the premises, for example, window restrictors and fire doors, were consistently maintained and safe. The provider had not made sure they were up to date with the latest legislation and health and safety guidance.
- At the time of the inspection there were no processes in place to review and analyse incidents, accidents and falls to identify trends. No action plans had been put in place to mitigate the risk of future reoccurrences.
- When assessing people's needs, the provider had not considered their registration requirements. For example, the provider is registered for older people (age 65 and over) and dementia. This had not been considered when admitting people with a primary diagnosis of learning disability and how they would meet their different needs. This meant the provider had admitted people into the home when they did not have the necessary Service User Band. The provider had failed to recognise they should have submitted a notification to us to request our consideration of adding the necessary Service User Band to their registration. We also found their Statement of purpose had not been reviewed to show how they intended to meet the needs of people with a learning disability. A Statement of purpose is a document provider's must submit to CQC describing what service they intend to provide, where it will be provided and who it will be

provided for.
● At the last inspection, the provider had failed to notify CQC of specific events they were legally obliged to do so. When reviewing DoLS applications it was discovered CQC had not been informed of application outcomes for eight people. The provider had failed to make the necessary improvements needed even though the same issues had been identified at previous inspections. This demonstrates the provider's lack of engagement and commitment to making the necessary improvements to the service.

We found no evidence people had been harmed. However, the continued failure to address inadequate monitoring of governance processes to make the necessary improvements to the service was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We saw peoples' and family members views had been sought by the provider. However, where issues had been identified there were no plans in place to demonstrate what action the provider had taken to address them. For example, on two of the feedback forms relatives had mentioned the smell of urine in the home. There had been no learning from this feedback as our findings discovered on the first day of our inspection.
● People and most relatives spoke positively about the leadership at the home. Comments included, "[Manager's name] is very good. They have been golden to [person]." "They [management team] are very good actually. [Person] has been in there for a while and there is nothing at the moment that worries me."
● Staff told us they felt supported by the manager. One staff member told us, "[Manager's name] is absolutely brilliant. You can go to her with anything."
● Staff told us they did have regular staff meetings and supervisions.

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals.

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 People did not always receive person centred care