A & I Care Home Ltd

The Meadows Residential Care Home

Inspection report

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14 September 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 13 and 14 September 2016. The first day of the inspection was unannounced and we told the deputy manager we would be returning the next day.

The last inspection visit took place on 21 December 2013 at which time all the assessed standards were being met.

The Meadows Residential Care Home provides care and accommodation for up to 24 older people who may also have dementia care needs. At the time of our inspection there were 23 people living at the service.

The owner was also the provider. The provider, his wife and daughter were part of the management team and were active in overseeing the service. The registered manager had been on long-term leave and had returned to the service the week prior to the inspection. During their absence, the deputy manager had managed 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.

We found one breach of the Regulations because the provider had not always followed procedures for raising safeguarding alerts to the local authority and notifications to the Care Quality Commission.

Care workers had attended safeguarding training and knew how to report safeguarding concerns.

Risks to people's safety and wellbeing had been assessed to keep people safe and staff knew how to record incidents and accidents. The provider followed safe recruitment procedures and there were enough staff deployed to meet people's needs.

There were a number of regular maintenance and service checks carried out to ensure the environment was safe. Medicines were administered and stored safely.

The deputy manager had made appropriate DoLS applications, however consent to care and treatment was not always sought in line with Mental Capacity Act (MCA) 2005 legislation. We recommended that consent is sought for care and treatment and where a person lacks mental capacity, the provider acts in accordance with the requirements of the Mental Capacity Act 2005.

People's nutritional needs were met and they were able to have food and drinks when they wanted to. People had access to health care services and the service worked with other community based agencies.

People who used the service told us staff were kind and their dignity and privacy was respected.

Comprehensive care plans recorded people's needs and goals and were reviewed monthly.

Activities were not meaningful for everyone who used the service. We recommended that the provider consult appropriate guidance and review activity provision.

All stakeholders indicated they could speak to one of the management team and felt they would be listened to.

The service had systems to monitor the quality of service delivered and ensure the needs of the people who used the service were being met.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Good

The service was safe.

Care workers had completed safeguarding training.

There were procedures in place to safeguard people from the risk of abuse and staff knew how to respond if they suspected abuse.

Risk assessments minimised harm to people using the service. There were safety checks and audits in place to maintain people's safety.

Safe recruitment procedures were being followed and there were enough staff to meet people's needs.

Medicines were administered and stored in a safe way.

Is the service effective?

Good

The service was effective.

However, the service did not always work within the principles of the Mental Capacity Act (2005) because people's consent to care and treatment was not always recorded.

Care staff received relevant training to enable them to have the skills to care for people effectively.

People were supported with nutritional needs to meet their individual requirements.

People's healthcare needs were met and we saw evidence of involvement with relevant healthcare professionals such as the GP and community psychiatric nurse.

Is the service caring?

Good

The service was caring.

People who used the service had developed positive relationships with staff.

People's choices, privacy and dignity were respected.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Good

The service was responsive.

Staff were aware of people's individual needs and they were able to identify the routines and preferences of people living in the service.

Activities were not meaningful for everyone who used the service.

People said they would speak with one of the management team about concerns they had and systems were in place to investigate and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not always raise safeguarding alerts with the local authority or make notifications as required by the Care Quality Commission.

The service had systems to monitor the quality of the service delivered to ensure the needs of the people who used the service were being met.

Maintenance and service checks were carried out to ensure the environment was safe.

People who used the service, relatives and staff said the management team was approachable and listened.

The Meadows Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 13 and 14 September 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day.

The inspection team on 13 September 2016 included an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had experience of caring for family members who use regulated services. The inspection on 14 September 2016 was carried out by an inspector only.

Prior to the inspection, the service completed a Provider Information Return (PIR). This form asked the provider to give some key information about the service, what the service did well and improvements they planned to make. Additionally, we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's Commissioning Team and Safeguarding Team.

During the inspection, we spoke with seven people who used the service and five relatives. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We interviewed seven staff including the registered manager and deputy manager and we spoke with a visiting social care professional. Following the inspection, we received feedback from a healthcare professional and collective feedback from GPs.

We looked at the care plans for five people who used the service. We also saw files for six staff which included recruitment records, supervisions, appraisals and training records.

We looked at medicines management for people who used the service. Additionally we looked at the environment, maintenance, servicing checks and audits.

Good

Is the service safe?

Our findings

People who used the service and their families told us it was safe. Comments included, "Yes (I feel safe). You can use the buzzer and someone can pick me up when I fall", "Yes. The doors are locked so no one can come in", "Haven't really thought about it, but it does feel safe - always people around", "I do feel as safe as you can be. You can get help when you want it", "I think she is safe. It took us a long time to find this home. This place feels like a home and it is good" and "She's well looked after. It's very safe."

Care workers told us they had recently undertaken safeguarding training and were able to identify types of abuse and how to respond appropriately. They said they would alert the manager or the provider to any concerns and if necessary notify the local authority or Care Quality Commission. Care workers would raise whistleblowing concerns with their manager or with the Care Quality Commission. However, we saw that kitchen staff had not had safeguarding training and would benefit from formal training in this area.

We saw individual risk assessment plans for each person who used the service. The risk was assessed and included actions to manage the risk and keep people as safe as possible. The risk assessments were reviewed three monthly or as required.

Staff recorded incidents and accidents, informed the manager and told us they would contact emergency services if required. The forms included a description, an action plan, a 24 hour monitoring form if required and recorded if the care plan needed to be updated as a result of the incident. Incidents and accidents were audited monthly and included what learning took place in order to prevent a similar situation.

Each person had a Personal Emergency Evacuation Plan (PEEP) indicating the methods of assistance to use to evacuate the premises and individual fire risk assessments that were reviewed every two months. Staff received monthly fire instruction. We saw up to date safety checks for fire equipment, weekly fire alarm tests and a staff fire drill record. Lifts, hoists and fire alarms had been checked by external services within the last year. Emergency equipment including first aid supplies and fire equipment were situated throughout the service. There was an up to date gas safety certificate and legionella testing carried out. We saw that fridge temperatures were checked daily and were told that the freezer temperature was checked daily but not recorded. The deputy manager said they would begin recording it with immediate effect. The monthly infection control audit included the environment and training and had an action plan with a time scale. The monthly safety monitoring checklist looked at risk assessments, hoist records, food temperature and storage, and incident reports. Each report recorded the action taken. There was an additional audit for transferring equipment such as wheelchairs and hoists. We saw a monthly audit of petty cash. Receipts were kept for purchases and expenditure was recorded. There was a three monthly pest control audit.

The service followed safe recruitment procedures to ensure staff were suitable to work with people who used the service. The care workers' files had application forms, two references, interview questions, Disclosure and Barring Service (DBS) checks, proof of identity and where required proof of permission to work.

During our inspection, we observed there were enough staff to meet the needs of the people in the service. The deputy manager told us the service did not use agency or bank staff as the care workers were very flexible about changing shifts if required. When we asked people who used the service and their relatives if there were enough staff they said, "Yes. You get a buzzer and you get someone within a couple of minutes. It is the same at night and the weekend - well seems to be anyway. I haven't noticed any difference", "Some days yes. Some days we have to wait to be served. Not that often though like once a week", "Yes, you have to wait your turn to be seen like 3-5 minutes", "I think so. There are more people here now than there used to be", "I've not really noticed but it appears to always have someone around. I think it is a small home so things like the bell gets answered. There is always two in the lounge, one nurse and lots floating around. Never felt it was understaffed" and "I've never seen anything that would question there not being enough." A relative told us, "They do most stuff really well. They seem to have the time to spend with the people who need it. The staffing ratio is very good. They're attentive." When we asked people how quickly call bells were answered, they told us, "Yes, they answer it straight away they are quite good at that", "Within a few minutes they do", "Yes, most of the time" and "Very quickly. That is normal anytime."

During the inspection we looked at medicines administration records (MAR) for six people including controlled drugs administration. Only five identified staff memebrs administered medicines. Medicines were dispensed from blister packs and information contained within MAR charts included people's photos and identified allergies. People who were receiving PRN (as required) medicines had a PRN protocol for administering the medicines. Controlled drugs were stored safely and we saw two signatures when these drugs were administered. There were no discrepancies in the recording of medicines administered and the samples of stocks we counted were accurate and could be reconciled with the records of administration. The weekly medicines audit checked stock, expiry dates, MAR sheets, the reason for missed medicines and the action required. This gave us assurance that medicines were being administered safely.

On 26 August 2016, a pharmacy technician from the Ealing Clinical Commissioning Group (CCG) visited the home and noted that "Overall the medicines management within the home had been run very well." They also made recommendations that we saw the service had implemented. The service had a medicines policy that covered relevant areas such as PRN (as required) medicines, controlled drugs, self-administration and who to notify of medicines errors. No one in the service was being administered medicines covertly but we saw the medicines policy lacked information on administering covert medicines should the need arise.

The environment was clean and relatives observed that, "The room is always lovely and clean" and "Her room is clean. The whole of the home is extremely clean."

Good

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.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The deputy manager understood their responsibilities under the MCA and had made appropriate DoLS applications with records of assessment dates and outcomes. The staff we spoke with also had a good understanding of MCA and gave us examples of people not being able to leave the home freely or having restrictive bedrails requiring a DoLS application or best interest decision to be made. This indicated staff understood the principles around choice and consent.

We looked at how capacity and consent to care was recorded. Files contained consent to care forms, consent to photos and, where appropriate, consent to bedrails. We saw that the consent form for the use of bedrails recorded that "Discussion with the resident's relative / representative for 'the best interest decision' should only take place for the residents who lack capacity to provide consent" indicating those forms were signed as the result of a best interest meeting. When other consent forms were signed by relatives it was not clear if people had been assessed as having capacity to consent, and if they did not have capacity, how a best interest decision had been made. Nor was it clear when relatives had Lasting Power of Attorney (LPoA) and if so for health and welfare or for finance. However, overall the evidence indicated the service understood the need for consent but were not consistently recording it.

We recommend that consent is sought for care and treatment and where a person lacks mental capacity, the provider acts in accordance with the requirements of the Mental Capacity Act 2005.

Care workers were supported to have the skills and knowledge they required to carry out their role through training and supervisions. We saw evidence of inductions and probation reviews and care workers we spoke with confirmed as part of the induction they read the policies and care plans and then had two days shadowing another member of staff. Training the provider considered mandatory included manual handling, infection control, dementia awareness, safeguarding and Mental Capacity Act 2005 (MCA) training. The team's most recent training was over four days in August 2016 by an external trainer who covered ten areas of training including safeguarding. The training matrix indicated the training staff had completed during a year but did not provide exact dates of when the training was completed. A relative told us, "They (staff) seem very knowledgeable."

Care workers told us they had supervision and appraisals. Staff who had been with the service for over a year had Individual performance reviews completed yearly. Supervision was every three months and we saw

records indicating staff had the opportunity to raise issues and that they were also given performance feedback. A care worker told us, "It (supervision) is useful because we can always share our views. What I really like is if something needs changing, they do it" and "It's very easy to ask questions because it's one to one."

We saw team meeting minutes for January, May and August 2016. In January, a management style called "Management by Objectives" was introduced. The January and May meetings were clearly about how changes would be implemented and managed. The August meeting indicated more staff involvement and discussed whistleblowing, end of life care and the notification policies. Team meetings provided opportunities for staff to be involved in providing feedback and contributing to how the service was run. Staff we spoke with said the changes, which included restructuring how shifts were led, had a positive effect on how the service was managed.

Care workers told us there was good communication in the service and we saw there was a handover between shifts three times a day and a communication book to keep staff updated of changes. Relatives said "They do keep me informed which I like" and "We are always kept up to date with any issues."

There were mixed views of the menu. People and relatives we spoke with said, "They are adequate, only up to a point. No menu. Sometimes they will cook me an omelette", "Good but sometimes not nice at all. Not enough flavouring. We can't choose what we are given", "They don't cook the English way. Mostly casserole type food", "It's alright I guess. We do get snacks with our teas", "It is good", "Pretty good but I am not a great eater", "She loves her food she is always saying the food is good. She always eats everything on her plate" and "Yes, like today she said I've had lunch and I am nice and full." Lunch was served at 12:30pm and dinner at 5pm but we were told people could ask for food at any time of the day. We observed that care workers supporting people with lunch were patient and spoke to the people they were assisting. There was a choice of three meals on the menu and we saw the cook asking people what they would like for lunch and dinner. A member of staff told us, "We ask people what they would like to eat to keep their appetite (and) will seek the dietician's advice if (we have) concerns around weight." People's likes, dislikes, supplements and dietary needs were recorded and kept in the kitchen.

People who used the service were supported to maintain good health and we saw from individual multi-disciplinary records that there was involvement with the memory clinic, the speech and language team, doctors and community psychiatric nurses. The care plans included information about people's nutrition and weight. These were reviewed monthly and signed off by staff. We asked people if they saw other health care professionals and they told us, "I go to them myself, I also make appointments myself. I am happy doing this", "I haven't needed to see one since I have been here" and "Someone will call the doctors for me if I need to see one. They are good with it."

We received collective feedback from a surgery with a number of GPs who cared for people living at the service. They told us that medical attention was usually sought appropriately and medical advice was generally followed. They noted that an increasing number of people were brought to the surgery for consultation and this worked well but when the GPs went to the home, the assumption was that people were seen in the common room, which was not satisfactory and it took time to support the person to a private room to be seen. They also said, "The staff seem to be caring and to know the residents well" and "They are usually able to give medical information and have an efficient record keeping system."

Another healthcare professional we spoke with said the staff were very patient and willing to help. They indicated staff were very much aware of systems around memory loss and how to react. "They're aware of risk and complication." "They are good at communication and taking advice and aware if they have

someone they are not able to care for. They deal with holistic care. It's not just every day care. They have activities and they bring other people in for all sorts of activities for the clients."

Good

Is the service caring?

Our findings

We observed that staff were kind and caring. People said, "Yes like there is one resident who likes to be independent but today he was struggling and one of the staff members made sure he was ok and helped him into a wheelchair and bought him down. They are good with everyone", "They are quite nice. Not bad at all", "I am well looked after. They seem very caring, but they don't have a lot of time" and "Very caring they will help you with anything you need." When we asked people who used the service how staff interacted with them, they told us, "They make sure you are alright and ask if they can do anything for you. Some of them will talk to you about what you used to do", "When they have the time they do (stop to talk) but they don't really have it. I can call to them and they will come and have a chat", "Sometimes the problem is they are all very busy", "They will listen and do anything they can do for you" and "They make sure I am alright." One person recited a very positive poem they had written about the home. Relatives told us, "When I've been here they hold her hand and ask her things like how she is doing and how was lunch", "I think it's wonderful. The staff are very, very good and caring. It's clean and the food is good. Good atmosphere", "I like the homely atmosphere, the care and friendliness. They are all helpful, positive and cheerful" and "It's been very good. She is well looked after."

We saw the service promoted choice and independence. The registered manager told us, "Residents are always valued. Their choices always come first." Relatives said "She can say what she wants to do", "They (staff) don't tell. They ask everything" and "They are so kind to her and they ask her everything. She's not dictated to in any way." A care worker told us, "Every person is different and we need to make sure they feel confident. I always make sure I know their name and knock on their door. We try to promote independence and get people to do things on their own. We always give them a choice of clothing."

Some people had open doors and others kept their doors closed but everyone we spoke with said staff knocked before entering. One person said, "The door is closed. Some knock on the door and the rest call my name. They wait before coming in. They don't just enter." When providing personal care, staff were aware of maintaining people's dignity and privacy. People's comments included, "I have an ensuite which remains open when I have a shower because I can get claustrophobic, but my bedroom door is closed", " They shut the door and care for me in private" and "Very good. They always make sure no one can look in when I am in the shower, toilet or getting dressed. I think they worry about it all more than I do." Care workers indicated they were sensitive to people's individual needs. One care worker said, "With personal care, treat people nicely and gently. Lots of people have skin problems so use wipes instead of flannels. Make sure the water is warm. I am explaining everything I'm going to do so they know." Another care worker demonstrated people's choice by telling us, "We have a shower list and if they don't want to (shower), we put a note in the 'shower book' and ask again. It depends how they feel." This was confirmed by a relative who said, "In the morning (their relative) might not want a shower. They always ask her and if she doesn't want one, they'll try again in the afternoon."

Good

Is the service responsive?

Our findings

We reviewed people's files to see if individual needs and preferences were met. Files contained pre-admission forms completed by the provider and placement referral forms from the local authority, which identified needs prior to placement, people's profiles, including life stories, care plans, daily routines, risk assessments, monthly reviews and documentation of input from other health professionals.

Care plans were comprehensive and recorded people's needs and goals. The care plans indicated people's views when they first came into the service and although they were updated monthly, people's views were not updated as frequently. Care plans noted preferences such as when people would like to get up in the morning, if they had a preference for a male or female carer and daily routines such as going to the hairdresser. At the end of each care plan was a section with information on how to support people's individual needs.

A senior care worker completed care plan reviews monthly. They told us that if people had capacity they discussed their care plan with them, and if not, the family signed the care plan whenever they could. Once, the reviews were completed, the registered manager updated the care plans. We saw evidence in the files of how information had been added and changed as the result of a review. A relative told us they did a "care plan when we came here and every now and again they show me and we update it if necessary" and another relative said when their relative moved to the home, "Staff sat and talked about the care plan." When we asked people if they were involved in making decisions about their care, they told us, "Probably could change things. When I came here there was only brown bread and I like white so now we have white bread as well", "Not forced to do anything. I can pick what I want to do", "I can think for myself and decide what I want. They won't do anything I don't want them to", "You can choose more or less" and "I have not been involved it is my brother that deals with that. He also gets all the paperwork."

During the inspection we observed several relatives visiting and people told us they could go out with their relatives when they wanted to. We also observed a volunteer at the service and care workers told us there were a number of Catholic people and a priest came every Sunday to visit those who could not attend church. A Church of England vicar also came once a month. Additionally holidays such as Christmas and St Patrick's Day were celebrated.

People's comments on the activities available included, "We played bingo the other afternoon, but no one here wants to do anything. They just want to sit in their chair and watch TV. I sit and read and watch some television and do my crosswords", "I think they do some but I don't bother", "There are activities like bingo and darts but I can't be bothered. I'd rather watch TV", "I don't want to do any of them", "I like sitting here watching TV" and "Not a lot. Bingo and things like that. I used to do karaoke but the machine is broken." The service had an activities co-ordinator who had a background in arts and crafts and had completed dementia and reminiscence training. The activity co-ordinator came in three afternoons a week, which they said was because they found if they came five days a week or full days, people did not participate as much. Activities included bowling, cards, parachute games and music and singing, some of which we observed during our visit. Sometimes they look at flowers on the iPad and a few weeks ago they went to Kew Gardens. The co-

ordinator said some people did not like to take part in activities but enjoyed watching the others. The activities co-ordinator made time to sit and talk with these people. The service also provided sensory arts and crafts and we observed several people looking through their own memory boxes with staff. Overall, we observed that while there were meaningful activities available to those more able to engage, there were not enough options for people who were less able to engage.

The National Institute of Clinical Excellence (NICE) Guidance for leisure activities and choice states "It is important that people with dementia can take part in leisure activities during their day that are meaningful to them. People have different interests and preferences about how they wish to spend their time. People with dementia are no exception but increasingly need the support of others to participate. Understanding this and how to enable people with dementia to take part in leisure activities can help maintain and improve quality of life."

We recommend that the provider consult appropriate guidance and review activity provision.

The service had a complaints procedure and complaint form record. We saw evidence the provider responded appropriately to complaints and in line with their procedures by recording the issues, response, outcome and lessons learned from the complaint. A relative observed, "How to make a complaint is all over the place. I've spoken to (the provider). They're all approachable." Other relatives said, "The manager is helpful and accommodates you. If I wanted to complain, I would see (the provider)", "They listen and try to address it" and "Mangers respond to anything we raise." A care worker noted there was a suggestion box which could be used anonymously or they could talk to the manager, provider or the Care Quality Commission "if it's serious" and "They're very good managers. We can come with everything to them." Another care worker said, "What I really like about the place is they always deal with the complaint straight away."

Requires Improvement

Is the service well-led?

Our findings

The service had an incident where a care worker raised their voice to a person using the service. The service dealt with the incident appropriately and began disciplinary procedures, however the incident was not raised as a safeguarding alert or reported to the Care Quality Commission as abuse or an allegation of abuse as required under the Regulations. The provider initially advised an alert was not raised because the care worker resigned and the family of the victim did not want to proceed with a safeguarding alert. After the inspection, the provider made available further information around the context of the incident. However, that the provider did not report the incident remained and indicated the provider did not always follow the principles around safeguarding.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The management team at the Meadows included the provider, who was also the owner, the registered manager and the deputy manager. The registered manager had been on long-term leave and had just returned to work. In their absence, the deputy manager had acted up into the manager's post. The management team were accessible. People we spoke with said of the provider, "I know his face, he is very pleasant and I think he is approachable", "I don't know his name but he is alright" and "I have spoken to him a few times. He is a nice person. I don't remember his name." Of the manager they said, "Very good", "She is not bad and the same with the owners" and "Lovely. She is very good. She introduces herself right away and seems to run a tight ship." People, relatives and professionals confirmed the registered manager and the deputy manager were visible and approachable. The registered manager told us, "I like visible leadership and I'm on the floor." A relative said, "What we like is you do see the manager. You do see the carers here on a very regular basis." A social care professional told us, the registered manager was "very cooperative and compliant. She listens to concerns and resolves (them). When I ask management, it's done" A care worker commented, "(The deputy manager) has excellent people skills. She's very, very approachable."

The service had systems to monitor the quality of service delivered. We saw a bimonthly audit which was a comprehensive check of the service and included the environment, new admissions, incidents and accidents and action taken, complaints, resident feedback, care plans, infection control and medicines. They had a five point action plan completed by the manager on the 31 August 2016 which was then reviewed by the provider who commented on how to achieve each action point. The registered manager and the provider discussed the service and audits about once a month. Audits were completed consistently and indicated outcomes and actions. This indicated the provider had a good overview of the service. Care plans were also monitored in areas such as weight and care plan reviews and a medicine audit was completed weekly. Incidents were recorded appropriately and an analysis undertaken monthly. Monitoring people's health and well-being meant the service could make changes to care plans as needed.

The provider had written up key challenges for 2016 and provided management actions to meet the challenges, which they shared with their staff team. This provided the whole staff team with an understanding of how the service was moving forward. A member of staff said, "We always have chances to learn and are motivated. They (provider) always motivates and encourages staff."

The last customer satisfaction surveys and visitor questionnaires were completed in September 2014. The service now relies on website reviews on Carehome.co.uk. for feedback. From 19 reviews in 2016, the service scored 9.8 out of 10.

People had the opportunity to attend residents' meetings which provided a forum for feedback. We saw minutes for meetings held in January, April and August 2016. Twelve people attended the meeting. Topics discussed included food, activities, staffing and both communal rooms and bedrooms. The feedback from people who used the service was generally positive.

The service kept up to date with current best practice and legislation through training with the local authority and the registered manager planned to start attending provider forums. The service had a good working relationship with various community-based professionals that contributed to them being able to meet people's individual needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Care Quality Commission of alleged abuse to a service user. Regulation 18 (2) (e)