Surrey and Borders Partnership NHS Foundation Trust

Derby House

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Derby House provides personal care and accommodation for up to eight females with a learning disability. This includes autism or behavioural difficulties.

There was no registered manager in post. The new manager had submitted his application to CQC to become registered. 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 and associated Regulations about how the service is run. The new manager assisted us with our inspection on the day.

Where people had identified risks, such as a risk of choking, staff did not always follow the guidance that was in place. For example, by sitting next to people whilst they were eating. Accidents and incidents were recorded and monitored but staff did not adhere to steps put in place to mitigate the reoccurrence of such incidents. For example, in relation to people choking.

Summary of findings

There were enough staff working to meet people's needs but deployment of staff was not always appropriate to ensure people had regular access to the community. Activities were arranged for people but we found there was a lack of oversight by management to ensure people received the level of activity they may be funded for.

People's dietary requirements had been identified by staff and although people were involved in developing the menu we did not see people being offered a choice of the food they ate.

Actions from quality assurance monitoring were not always completed to help improve the care and treatment people received. We found staff behaviour was not always open or transparent. The provider only acted on concerns once they had been identified by us during our inspection.

Although we saw some good examples of care, we found staff did not always show people respect, speak to them in an appropriate manner or provide them with care personalised for their needs. Care records in relation to people were detailed and comprehensive but did not always focus on the person as an individual.

Staff were provided with regular training to assist them with carrying out their role and staff had the opportunity to meet with their line manager to check they were following best practice and to discuss any aspect of their work.

Staff had a good understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards, which meant staff had followed the correct procedures in relation to any restrictions that were in place.

Staff had a clear understanding of how to safeguard people and knew what steps they should take if they suspected abuse. In the event of an emergency or the home had to be evacuated people's care and support would not be interrupted.

Good medicine management procedures were followed by staff and guidance was in place for staff to indicate when people may require medicines for pain. People were supported to access external health care professionals when required in order to help them maintain a good level of health.

Staff were involved in all aspects of the home and attended regular staff meetings. Staff felt supported by the manager. There was complaint information available for people should they have any concerns about the care they were receiving. Relatives were asked for their feedback in relation to the home and were made to feel welcome when they visited.

During the inspection we found breaches 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.

Summary of findings

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 safe.

Staff did not act on known risks which placed people at the risk of harm. Where incidents had been identified action was taken to reduce the risk of harm but not always followed by staff.

There were enough staff to meet people's needs, but staff were not always deployed appropriately.

Staff followed good medicines management procedures.

Staff understood what abuse was and knew how to report it should they suspect it.

Guidance was in place for staff and people should there be an emergency at the home.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were not always given appropriate food and although people were involved in developing menus they were not given a choice at mealtimes.

Staff followed legal requirements in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff were provided with support in relation to their role, for example through training, supervisions and annual appraisals.

People had access to healthcare services to maintain good health. Staff provide care which was effective.

Is the service caring?

Requires improvement

The service was not caring.

People were not always treated with kindness or their dignity respected.

People were not always encouraged by staff to be independent.

Care was not always centred on people's individual needs.

Visitors were welcome in the home.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care plans were extensive and contained relevant information, however staff did not focus on people's individual preferences.

Summary of findings

Activities were available for people, however people could not always access the activities they preferred as often as they would like. There was complaint information made available to people.	
Is the service well-led? The service was not well-led. Quality assurance audits were not always followed up by staff. There was inconsistent attitude by staff. Relative's views were sought on the home. Staff thought the manager was supportive and they could go to them with any concerns. People and staff were involved in the running of the home.	**Requires improvement** 

Derby House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place on the 1 December2015. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed the information we had about the service. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks

the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we carried out this inspection sooner than we had planned. Instead we reviewed all of the notifications of significant events that affected the running of the service. A notification is information about important events which the service is required to send us by law.

As people living at Derby House were unable to tell us about their experiences, we observed the care and support being provided and talked to relatives and other people involved in their care following the inspection.

We spoke with three relatives, three staff, the manager and one health and social care professional to gain their feedback as to the care that people received. We looked at a range of records about people's care and how the home was managed. For example, we looked at two care plans, medication administration records, risk assessments, accident and incident records, complaints records and internal and external audits that had been completed.

We last inspected Derby House in July 2014 where we identified a breach of regulation in relation to good governance.

Requires improvement

Is the service safe?

Our findings

We found that people were at risk of harm at mealtimes. Staff did not always follow guidance in relation to risks associated with choking. Three people had been identified as needing staff support to encourage them to eat slowly to reduce the risk of them choking. Their care records stated that staff should sit with them whilst they ate however this did not happen on the day of the inspection. As a result we saw one person start to choke whilst eating some fruit. Another person ate their meal whilst standing and were not supported by staff who did not notice they ate their meal quickly.

Another person needed to eat with a long handled spoon to assist them to eat smaller mouthfuls of food however they were given a dessert spoon to eat with by staff. This resulted in them eating the whole of their dinner (macaroni cheese) quickly as they were able to eat larger mouthfuls of food than was safe for them. As the meal got colder, the cheese congealed together meaning they put more in their mouth which could increase their risk of choking. We heard a staff member say to this person to eat, "Slowly" but they did not look at the person when they said this and did not check the speed at which they were eating.

Staff told us that people in the home were at risk of choking but we found no guidance readily available for staff to refer to. Instead guidance from the relevant healthcare professionals was stored in people's care records. In addition, neither the manager or staff were aware of further such as the local authority's choking policy which may help them follow good practice. Although the manager had clearly sought guidance from external health professionals in relation to the risks people may face in relation to their food. After the inspection we asked the provider to take action to ensure that people were safe during mealtimes. We subsequently spoke with a healthcare professional who told us they had visited the home to reassess people and they found staff sat with people during their mealtimes and had guidance available to them.

Incidents of choking were recorded by staff and steps were introduced to try to avoid them reoccurring however, this was not always followed by staff. There had been two recent incidents related where two people who were choking on their food. Staff had taken appropriate action in both situations and people had been unharmed but recommended steps to avoid this happening again by staff sitting with people at mealtimes were not adhered to.

Staff did not always recognise when people's behaviour may be a risk to others. One person's care plan stated that they may be aggressive towards other people and visitors. When we arrived at the home, one person approached an inspector as if to embrace them but then very quickly they grabbed them around the neck. Staff did not anticipate this or take action to warn them that this may happen.

Failure to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people had been identified and guidance was in place for staff to help mitigate the risk of people being harmed in certain situations. We saw risk assessments for people in relation to mobility, going out and having a bath. For example, we saw people had guidance around the risk of them being in the provider's vehicle and how staff should always ensure two staff accompanied people when they went out into the community. Staff told us this always happened.

There were sufficient members of staff on duty to meet people's needs, however deployment of staff needed to be better managed. We were told that one qualified nursing staff member was on duty each day in addition to three members of care staff. We looked at the staffing rotas for the previous three months and saw that the numbers of staff scheduled to work matched what we had been told. The manager said in the event of staff shortage or sickness agency staff would be used. They told us they would try to ensure they used the same agency staff to reduce people's anxieties of meeting a stranger. We did not see people on the day waiting for staff to assist them and always saw plenty of staff around.

However we found that only three of the 15 members of staff were able to drive the provider's vehicle, which included the manager. This meant that there were times that staff on duty were non-drivers and therefore people may be unable to go out. The manager told us they were often included on the rota. Although we found this did not improve the situation as he would be unable to leave the home as the most senior person on duty.

Requires improvement

Is the service safe?

We recommend the provider reviews their deployment of staff to ensure people have access to the community.

Safe medicines management processes were carried out by staff. We reviewed Medicines Administration Records (MARs) charts and found these were completed correctly. For example, we saw where staff had handwritten in medicines details and dosage this was signed by two staff members. Where people received their medicines at a time that was different than stated on their MAR chart we found staff were following the medicines policy by recording the actual time the medicines were administered.

MAR charts had people's personal information on them and a photograph to help ensure staff gave medicines to the correct person. We read guidance for staff to show how people liked to take their medicines and there was guidance in place for pain or allergy relief when relevant. Staff were knowledgeable about the medicines process and we saw medicines were stored safely and securely in a locked room.

People were safeguarded from the risk of abuse. There was a safeguarding policy that guided staff on the correct steps to take if they had a concern and staff knew how to access this. Staff had received training in safeguarding people. Staff understood how to whistleblow if they had a concern that they wanted to report and knew about the role the local authority played in safeguarding people. We noted safeguarding was discussed at staff meetings and we saw a copy of Surrey's multi-agency policy was available for staff. Displayed in a prominent area in a way people could understand we saw safeguarding information for the people living in the home.

In the event of an emergency, such as the building being flooded or a fire, there was a contingency plan which detailed what staff needed to do to protect people and make them safe. There were personal evacuation plans for each person in their care plans which gave information to staff on how to ensure they evacuated people safely without causing them any distress.

Requires improvement

Is the service effective?

Our findings

People were not always involved in choosing what they had to eat and drink. Staff told us they sat with people to develop the menu by using pictures of food and encouraging people to choose what they wished to eat. This was then turned into a three-week rolling menu. Once the menu was developed it was sent to a dietician for their input to ensure it provided a good nutritional range of foods for people. We saw plenty of fresh food in the cupboards. We were told people were offered a choice of meal each day however we did not see that happen during our visit. Although a pictoral menu board was displayed in the dining room (so people could see what food was going to be offered to them) we found this did not reflect what people were actually served on the day.

Where people had identified dietary risks we saw staff served people's food in an appropriate way. For example, cutting food into small pieces. However, although the Speech and Language Therapy (SaLT) team had assessed people, we did not see information or guidance displayed so new or agency staff could access it easily. We were told staff would need to look in people's care records for this information. One person had a tendency to lose weight and we noted that staff kept a record of their food and fluid intake. We read staff weighed this person each month to monitor their weight which would help them to identify if this person was at risk.

We found the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were implemented appropriately. 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether staff were working within the principles of the MCA.

We read were people were unable to make decisions for themselves, staff had followed legal requirements. For example, we read people's capacity had been assessed and best interest meetings had been held for particular decisions. We read where staff were considering holding a best interest meeting for one person who required dental treatment. Staff ensured people's consent was sought when appropriate. For example, staff asked people if they were happy that we looked in their rooms.

Staff had taken action to keep people safe but had recognised people were being restricted of their liberty by doing this. For example, the front door to Derby House was locked as well as some cupboards in people's rooms and the kitchen. We found DoLS applications had been submitted appropriately to the local authority in respect of this.

People were cared for by staff who had access to a sufficient amount of training to help them develop appropriate skills for their role. Staff received training specific to the needs of the people they cared for. For example, challenging behaviour and MAYBO (conflict resolution) training. Staff received regular ongoing training to ensure their skills where kept up to date. One member of staff told us, "The training gives me the skills I need. I feel confident to provide care."

Staff had the opportunity to meet with their manager on a regular basis as the manager carried out supervisions and annual appraisals. Supervisions and appraisals are important as they enable management to check staff are putting training into best practice and they give staff the opportunity to discuss any aspect of their work with their manager. One staff member told us they had supervisions and appraisals and could ask for additional training if they wished it. For example, training which would help them to develop professionally. Clinical supervisions were carried out by the manager to help ensure clinical staff were carrying out their duties in an appropriate way.

Staff provided care that proved effective. For example, one staff member told us one person would not have previously gone out from the home. They had gradually supported this person to feel more comfortable outside, amongst other people, and this person was now able to eat their lunch out in a café. Two staff members we spoke with told us of the way they would approach someone when they

Requires improvement

Is the service effective?

were displaying certain behaviours, this showed there was a consistent approach by staff. A relative said, “Before she came to Derby House she was up and down, but she’s much more settled now.”

People were supported to maintain good health by staff. We saw evidence in people’s care records that external health care professional advice and input was sought when appropriate. For example, the doctor, dentist or a psychiatrist. We saw one person going to a clinic appointment on the day of our inspection. We saw one person had swollen feet and ask staff about this. They said this person had been taken to the GP. We read another person required an eye examination and this had taken place. A relative told us, “If she needs a doctor they arrange it and always phone me immediately to tell me.”

Requires improvement

Is the service caring?

Our findings

One relative told us, "We've been very happy with the care she receives." Another said, "It's the best place she's been to. Staff are very good to her."

Despite these comments we found that staff did not always treat people with respect or speak to them in a caring way. For example, we heard a member of staff say to one person after the person become agitated, "Enough, otherwise you will go into the other room and you won't come back." Another person was constantly screaming during the day, the same member of staff held their head and said, "Oh my God, my head hurts" in response to this rather than acting to see what they could do to stop the behaviour continuing or relieve the persons distress. One person kissed a member of staff on the cheek, to which the member of staff responded, "No, don't do that."

Two people regularly said, "Gallwey" to staff which was the day centre next door to Derby Lodge. It clearly meant a lot to people as we were told by one person how much they enjoyed going there. However, we heard staff respond by saying, "It's not your time to go to Gallwey, you have to do your puzzles." Another person displayed behaviour which caused both them and other's distress. Staff told us they often displayed this behaviour when they came back from outings. Despite staff telling us their strategies on how to calm this person down we did not always see staff put this into practice. This resulted in other people holding their hands over their ears and becoming upset due to the noise from another person displaying anxiety.

People were not always given the respect they were entitled to. At lunch time people's food was served from a large metal trolley and people were given their lunch on plastic plates. Staff did not sit with people and engage during lunchtime, instead we observed staff chatting amongst themselves. We saw an occasion where one person reached out and took hold of a bag another person was holding. A staff member very sharply tugged the bag out of the person's hand, rather than encouraging them in an appropriate way to let go. Staff referred to the home as a "Ward" and people as, "Patients" which gave the home an institutional feel. A healthcare professional commented the home felt chaotic and staff response to people was often reactive.

People lived in a clean and spacious environment and individual's bedrooms were personalised with people's own belongings and items. However, areas of the home were sparse in terms of furnishings and it had a clinical feel to it. The lounge areas did not have items which would make it feel like someone's home and we found nothing that people could touch or look at. The walls and décor were stark and gave the environment a clinical feel like that of a hospital.

There was an inconsistent approach by staff and people were not always supported to be independent. One person asked for a cup of tea several times throughout the day however staff did not act upon this. Their care record stated they should be supported by staff to help make it. However, we did see staff encourage people to take their own laundry to the laundry room. Two people preferred to have their bedroom doors locked and they held their own keys.

People's cultural preferences were not always recognised by staff. For example, one person had written in their care records, 'I like to say Grace before meals' but we did not see this happen at lunch time.

People's individual ways of communicating were not always recognised or observed to be used by staff. We read a 'dictionary' of people's communication was recorded in their care records. Some people were able to use Makaton (signs and symbols) and we saw staff respond to this. Where people's speech was slightly impaired, staff were patient and listened to people when they were telling staff something to give them a chance to be understood. However this approach was inconsistent as we did not see staff use Makaton with one person who could communicate this way.

The above examples are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could have privacy when they wished it and were encouraged to be independent when they were able to. We heard how one person liked to spend time in their room, particularly in the afternoon and we saw this happen on the day. Staff recognised this and respected their wishes and we observed staff always knocking on people's doors before they entered their room.

We saw some examples of kind caring interaction from staff. For example, we saw staff comfort one person when they became upset and encourage and distract them.

Requires improvement

Is the service caring?

Another staff member checked someone had a cardigan on when they were going to walk across to the day centre. One person held a staff member's hands and we saw them and the staff member hug each other.

Staff knew people well and were able to tell us about people's histories, what they enjoyed and what upset them. We saw people respond to staff in a positive way and smile or show affection.

Visitors were welcome in the home. Relative's told us they were made to feel welcome. They said they knew the staff well as many of them had worked at the home for several years. One relative told us, "I always go to the Christmas party."

Requires improvement

Is the service responsive?

Our findings

People may not have been appropriately assessed to ensure that Derby House was the most suitable place for them to live in before they moved in. One person's care records stated they 'like to live in my own home that I did not have to share with people'. It also recorded that they would communicate by 'shouting/screaming when not happy, bored or in pain'. We saw and heard this person behave this way throughout the inspection and, although staff told us this was because we were at the home, they also said the person routinely shouted and screamed. There had been involvement with external health care professionals but they had not been able to determine why this was or reduce this happening.

Whilst care plans were comprehensive and detailed people's care needs we found people's person-centred plans written in terms of what could be provided in the home, rather than what people wished or what they wanted to achieve. For example, one person's care plan noted, 'offer a bath every morning' as this was what they preferred but their weekly activity plan showed us they were given a bath early evenings which contradicted what they wanted. Care records did not accurately reflect the care that the person wanted or that they received. In one section relating to what was important to them it stated 'my personal care' however in other care records that we saw it was written, 'I do not like any aspect of personal care. Does not like having a bath or shower'. For another person staff had written, 'We make sure she gets out every day' but we did not see staff support this person to go out during our inspection.

Care plans contained information on people's dietary preferences, any food risks, individual goal plans and a personal profile. We read each person had a hospital passport which recorded important information about a person should they have to go into hospital. Care plans had been reviewed and changes were noted and a communications book used to relay these changes to all staff. However, we found the care records were not always person-centred and from our observations (particularly during lunch time) we found staff did not always follow the guidance contained in them.

The lack of appropriate person centred care planning was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always given the opportunity to attend activities that they enjoyed. People clearly enjoyed attending the day centre (Gallwey) located next door to the home and people were able to attend this at certain times throughout the week. The manager did not know the amount of funding available for peoples activities and as a result could not be sure people had the opportunity to attend the day centre as often as they may like despite there being capacity (at the day centre) for this to happen. One person in particular benefitted from attending Gallwey as the behaviour they displayed at Derby House significantly reduced when they were at the day centre. A member of staff told us people's behaviours were, "Totally different" when they were out of the home and they were calm and enjoyed their time out. They said, "The minute they walk in (to the home) it's boredom."

People had individualised weekly activity charts, although we found in some cases this was limited which showed us people were not necessarily accessing the community or receiving individualised, meaningful activities they may be entitled to. For example, one person's weekly plan showed they received seven and a half hours of structured activity every other week. During the alternate week, this reduced to six and a half. We found this was similar for other people.

We read during the remaining hours people received 'in-house support' from staff. However, we did not see any items around the home which would indicate to us activities took part. We saw one person doing puzzles on their own and another had their hair and makeup done. However, one person sat in one lounge area, with the television on, all afternoon with no or limited social interaction from staff. As a consequence we saw they were asleep the majority of the time.

One person had written in their care records in relation to what was important to them, 'going for drives'. Another had stated, 'my three wishes – to go out for a drive every day, to have lots of cups of tea and like to pour it myself, I don't like being bored. I like a visual schedule'. We spoke with staff about this and were told that they would like to take people out more, but they had a limited number of staff drivers. A member of staff said they had raised this with senior management who had promised to recruit a dedicated driver but this had not yet happened. We were

Requires improvement

Is the service responsive?

told by staff they would take people for, "A walk" as an activity. However, we noted in one person's care records they, 'hate walking'. We were also told there was a lot of, "Grooming" in the morning as part of people's activities.

Following the inspection the manager wrote to tell us of the outings that had taken place for people between August and November 2015. This included trips to the seaside or London however we noted that two of the seven people living in the home had not been included in any of these trips.

We recommend the provider ensures people have access to activities which are individualised and meaningful for them.

One relative said, "They take her out and about and there are plenty of things for her to do. She's even been on holiday." They added, "Her quality of life is very good at Derby House." Activities were arranged for people which allowed them to access the community and meet other people. We saw two people walked to the day centre themselves. Staff told us they would telephone in advance to let the day centre know the person was on their way and when they arrived staff would confirm their arrival. People mentioned the day centre regularly throughout our inspection which indicated to us they enjoyed going there.

Complaint information was made available to people in a way they would understand. This was displayed clearly for people. The manager told us no formal complaints had been received since they had worked there. They told us they knew there were timescales in order to respond to any complaints received. Relative's told us they would talk to staff or the manager if they had any concerns. They told us the new manager had contacted them to introduce themselves.

Requires improvement

Is the service well-led?

Our findings

The manager, staff and the provider undertook regular quality assurance audits to help check the quality of care being provided at the home and that the home was a safe environment for people to live in. However, actions identified by them were not always completed to help improve quality. For example, the provider carried out compliance reviews on the quality and safety of the care provided. We looked at the reviews from July and September 2015 which focussed on different elements such as the environment, cleanliness, care plans and safeguarding. We read in the July 2015 review that the provider had identified some care plans were not up to date or person-centred. This was what we had found during our inspection which showed us that the manager and staff had not taken action to address this.

Other quality assurance checks were undertaken by staff. For example, we saw staff carried out a weekly medical devices audit and water temperature checks. We did find actions identified in some audits had been completed as follow-up audits reflected an improvement. For example, we looked at the infection control audit carried out in September 2015 where compliance was 79%. We saw a further audit was completed in October 2015 and compliance was 93%.

Staff behaviour was not always appropriate which in some cases meant that staff were not always open and transparent about how the service was run. When we arrived at the home, we were shown into the manager's office by a member of staff. They left us to fetch something and upon leaving the office locked the door without any explanation. When they returned we asked why they had done this and were told that one person would destroy the paperwork in the office if the door was unlocked however this had not been explained to us. On another occasion a manager who had arrived to offer support for the inspection told us it appeared that a staff member was, "Making it up as they went along" when we were discussing a query with them. However, we later overheard them say, "I don't want you to think that you will be getting into trouble for saying one thing and then another."

Care and support was not guided by good practice. We found that action was only taken by the provider after we raised concerns following our inspection. For example, although guidance was in place for staff in relation to people's risk of choking, the manager had not ensured staff were following this guidance despite working alongside staff when they were on duty.

The manager did not know about the funding for people's care and there were no records available in the home in relation to this which meant that they could not be sure that they were providing all the care people may be entitled to. For example, people's access to activities. Incidents and accidents had been identified for trends and patterns however the changes that were recommended as a result had not been consistently embedded into staff practice which had placed people at the risk of harm. Our inspection identified a number of breaches of regulations that should have been identified had there been effective quality assurance systems.

The lack of good management oversight and quality assurance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had the opportunity to be involved in the home. We read notes from meetings where people were encouraged to express their wishes in relation to outings and household jobs. We saw at one meeting in September people had indicated they would like to go on a trip to the seaside. The manager told us this had happened.

Staff were involved and kept up to date in the running of the home via team meetings. Staff told us they had regular staff meetings and felt confident to speak up in the meetings to offer suggestions or ideas. Meetings included discussions on all aspects of the home as well as giving the manager the opportunity to cascade any important information in relation to Derby House or the provider to staff. Staff told us they felt supported. One member of staff told us, "The manager is someone I can approach."

Relatives were encouraged to give their feedback about the home. We looked at the result of the last relative's survey and saw this had focussed on the external and internal appearance of the home. We read relatives were happy with both. One relative told us, "The environment is lovely."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured actions had been taken to mitigate risks to people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider had not ensured people always received person-centred care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured people were treated with respect and dignity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured good quality assurance processes.**