Mr John Scarman and Mrs Phaik Choo Scarman

Beech Haven Residential Care Home

Inspection report

15-19 Gordon Road
Ealing
London
W5 2AD

Tel: 02089910658
Website: www.beechhaven-carehome.co.uk/beech-haven

Date of inspection visit:
11 September 2018

Date of publication:
23 October 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 11 September 2018 and was unannounced.

The last inspection of the service was on 18 October 2016, when we rated the service good.

At this inspection on 11 September 2018 we rated the service requires improvement overall and for the questions, 'Is the service safe?' and 'Is the service well-led?' We have rated the key questions, 'Is the service effective?', 'Is the service caring?' and 'Is the service responsive?' as good.

Beech Haven Residential Care Home is a care home for up to 30 older people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 29 people were living at the service.

The service is owned and managed by a partnership and a family run business. There are four members of the same family who work together to manage the service. One of the partners is also the registered manager. 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.

Medicines were not always being safely managed and some of the risks to the health and wellbeing of people who lived at the service had not been mitigated.

The systems for recruiting new staff were not always effective because they did not include thorough checks on their suitability to work with vulnerable people.

Whilst the provider had systems for monitoring the quality of the service, these had failed to identify the risks relating to medicines and health and safety.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, fit and proper persons employed and good governance.

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

Following our feedback at the end of the inspection visit, the provider made improvements in all areas where we had identified concerns. They sent us information about these improvements.

People living at the service and their relatives were happy there. They felt their needs were being met and they found the staff kind, caring and compassionate. We observed that interactions between staff and

people living at the service were caring and demonstrated affection.

The staff felt well supported and had the training they needed to carry out their roles and responsibilities. The staff enjoyed working at the service and appeared confident and knowledgeable about the people who they were caring for.

The atmosphere and culture at the service were reflective of a family run business. The owners and their family were involved in the day to day running of the service and were well known, liked and respected by people who lived there, staff and visitors. People felt reassured that the owners were available whenever they needed. They felt that their concerns were addressed and were happy to raise these with one of the owners.

There had been improvements to some areas of the building, with refurbishment of communal rooms and bedrooms. Further improvements were planned. The home was accessible for people with mobility needs and people were able to access communal rooms, the garden and their bedrooms without restrictions. The home was generally clean, although some areas needed deep cleaning or redecoration. The provider had a plan to address these areas.

People had enough to eat and drink, and most people liked the food.

People's needs were assessed, planned for and being met. These needs were recorded in care plans, which they had been involved in creating. The staff monitored their wellbeing and responded appropriately to changes in their health, wellbeing and following an accident. There were assessments designed to guide the staff on how to minimise risks associated with each person's needs. These had been regularly reviewed and updated.

The provider had systems for monitoring the service and learning from when things went wrong. They had regular management meetings where they discussed service development. These included reflecting on feedback from other agencies, such as visits from the local authority. There was evidence that they planned further improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were not always safely managed.

There was a risk to people's health and wellbeing because chemical cleaning products were not always securely stored or labelled, and clinical waste was not always disposed of safely.

The provider's recruitment checks were not always sufficient to ensure the staff were suitable.

There were procedures designed to safeguard people from abuse.

The risks to people's safety and wellbeing had been assessed and planned for.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed, and care and treatment planned to reflect these.

The staff had the skills, knowledge and experience to deliver effective care and support.

People's individual needs were met by the design and adaptations of the premise.

Consent to care and treatment was sought in line with legislation and guidance, although this was not always clearly recorded.

People had access to healthcare services and received support with their healthcare needs.

People had enough to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion.

People were encouraged to express their views and were involved in decision making.

People's privacy, dignity and independence were respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their needs.

People's concerns and complaints were listened to and responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had not always identified risks to people's safety and wellbeing.

However, they took action to mitigate these and respond to other concerns when they became aware of these.

The service is a family run business and there was a positive culture which people using the service, staff and visitors all felt was a key quality.

People felt able to engage with the provider and share their experiences.

The provider had systems and processes for improving the quality of the service and plans for continuous improvement.

Beech Haven 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.

This was a comprehensive inspection which took place on 11 September 2018 and was unannounced.

The inspection team consisted of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report, information we had received from the local authority and members of the public and notifications from the provider. 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. The provider had completed a Provider Information Return (PIR) on 3 August 2018. The PIR 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. In addition, we also looked at information shared on public websites, including the provider's own website, about the service.

During the inspection we spoke with eight people who used the service, three visitors and staff on duty who included care assistants and the chef. We spoke with two of the managers (one was part of the provider's registered partnership).

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for 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 looked at the full care records for three people who used the service and part of the care records for a further three people. We looked at how medicines were being managed. We looked at the staff files for four members of staff. We also looked at other records used by the provider for managing the service, such as meeting minutes, environmental checks and other checks. We spent time with the managers discussing different aspects of the service and gave them feedback about our findings at the end of the inspection.

Requires Improvement

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe living there. They said they did not have any concerns and that the staff were kind and trustworthy.

People explained they were happy with the way in which their medicines were administered. However, we identified that this was not always safely managed. We found a supply of insulin (a medicine used in the management of diabetes) which had passed the expiry date and was still being used. This meant that there was a risk that the medicine was not safe. We discussed this with the owners who removed the out of date medicines.

Some of the systems being used to manage medicines did not effectively mitigate risks. For example, there were not always protocols in place for the administration of PRN (as required) medicines. This meant that the staff did not have guidance about when they should administer these. Some PRN pain killers were being administered regularly. In one case, the provider had discussed this with the prescribing doctor, however they had not done this for other people. For these people, their medicines needed to be reviewed to make sure the prescription and treatment they received met their needs.

Some people were prescribed medicated creams. The staff did not record the administration of this. This meant the provider could not judge whether people had received these creams as prescribed or whether there had been any concerns relating to the administration of these.

We observed that records of some medicines administered at 7am on the day of the inspection had not been recorded. However, later in the day (after 12pm) these records were signed. We discussed this with the owners because medicines administration records should be accurate and contemporaneous. There is a risk that these would not be accurate if completed at a later time or date.

The processes for stock control and rotation of medicines were not always effective. The staff did not record the date of opening of boxed medicines and the receipt, stock and balance of medicines were not clearly recorded. In some cases, we found large supplies of medicines which were not regularly used. This meant there was a risk that medicines may expire and meant that auditing whether people had received their medicines as prescribed was not possible.

During the morning of the inspection we identified two bottles of cleaning fluid were stored in a bathroom. They had not been securely stored. Furthermore, the label of one product was so badly worn that it was impossible to identify the product or information. This meant that if someone was to accidently ingest, spill or otherwise harm themselves with this product, they may not receive the correct medical intervention and treatment because it was not clear what the product was. Different responses are required for different types of chemical accident.

An unattended bag containing soiled continence aids had been left in another communal bathroom. The

bag had not been tied or secured. This presented a risk of the spread of infection.

We alerted the provider to the hazards we had identified, and they removed these.

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

Following the inspection visit, the provider wrote to us to tell us that they had provided additional training and guidance to staff in respect of safe medicines management, safe handling of chemicals and infection control. They had also introduced records so that medicated cream application could be recorded and more thorough checks on audits on all medicines.

The provider had not always carried out sufficient checks on staff suitability during their recruitment. We viewed the staff files for four members of staff who were employed and working at the service. There was no employment history recorded for three of the staff and an incomplete history for the fourth person. None of the staff files contained professional references. One did not contain any references and another file contained references which had been written before recruitment and brought by the staff to the provider rather than the provider requesting them. Therefore, their authenticity could not be verified. The other two staff files contained references written by friends, and in one case by the staff member's sibling. Therefore, these references could not be relied upon as an accurate reflection of the staff member's qualities and competencies. This alongside a lack of evidence regarding their previous employment meant that the provider could not guarantee they were suitable. Furthermore, one staff member had been employed on a part time contract because they had been given leave to stay in the country on a student visa. However, the records indicated the course the person was studying had ended in 2012 and there was no evidence that the provider had sought assurances that they were still permitted to work in the United Kingdom.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection visit, the provider told us they had improved the way information was recorded within staff files so that they would more easily be able to identify any gaps in employment histories or details.

We identified a few minor health and safety concerns which we also alerted the provider to. These included a missing light bulb from a corridor, which was well lit by sunlight in the day, but would not receive light from other sources at night, and therefore could present a risk for those using this corridor. There was also staining on some carpets, a slight malodour in one part of the house and a broken pane of glass which could present a risk if someone was to touch it. Following the visit, the provider wrote to us to tell us about work which they had undertaken to repair these faults, along with information about additional work they were carrying out.

We also found that two people's dentures were being stored in unlabelled containers. One in a toilet room next to a person's bedroom, but the other in the lounge. There was an incident where a visitor accidently knocked the dentures on to the floor and picked them up again but did not alert staff. We told the provider about this so that they could be cleaned and stored appropriately.

The last check of the electrical installation was in 2012 and this meant that the system needed to be checked again to ensure it was safe. The provider told us that this check had been arranged.

The local authority environmental health department had carried out inspections of the premises. They had found improvements were needed in respect of the kitchen, some risk assessments, procedures and training and evidence of lift servicing. The provider discussed the action they had taken in respect of these areas and the evidence they had supplied to the local authority.

The provider told us that London Fire Brigade had carried out an inspection of fire safety, but they had not received the report of this visit at the time of our inspection.

There was evidence that the provider undertook checks of health and safety at the service, including checks on equipment, electrical appliances and fire safety. Individual emergency evacuation plans had been created for each person, with instructions for staff about the support they would need in an emergency. The provider employed a maintenance person who oversaw checks and carried out minor repairs and work.

In general, we observed that staff followed safe practices when supporting people to move. However, we noted one incident where the staff did not secure the brake on someone's wheelchair when they supported them to move from this to a chair. This meant there was an increased risk of an accident. We discussed this with the provider who agreed to speak with the staff about this. The staff had taken part in regular training regarding how to assist people to move safely, and the provider observed their practice and competency in this respect.

The risks associated with people's physical and mental health needs had been assessed and incorporated into care plans. There was guidance for the staff on how to minimise these risks and these assessments were regularly reviewed.

There were procedures for safeguarding adults and whistle blowing. The staff had training in these. We saw that these areas were discussed in staff meetings and individual supervision meetings. The staff we spoke with knew what they would do if they had concerns that someone was being abused.

Accidents and incidents were all recorded and managers were involved in analysing what went wrong and whether they could make changes to improve the service. For example, following changes in one person's mobility needs, they had equipped some corridors and bathrooms with additional grab rails.

The provider had taken appropriate action during a recent incident where a person, who had left the home to go into the community, had become lost. Following the person's return to the service, they had put in place additional safeguards to reduce the risk of reoccurrence.

There were enough staff employed to keep people safe and meet their needs. There was one of the owners working or on call at all times and they worked alongside the staff. People told us they did not have to wait for care and support. They felt there were enough staff. They said that call bells were answered promptly.

Good

Is the service effective?

Our findings

People's needs and choices were assessed when they moved to the service. One of the managers met with the person and their family to discuss their medical history, history of falls and their current needs. These were recorded in clear assessments which went on to form the person's plan of care. People told us they had discussed their needs and how these should be met with the provider.

People were supported by staff who received training and had information about how to care for them. The provider had signed up for an online training service where the staff could access different training subjects in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The provider told us they supported some staff to access these courses, in particular if they had limited computer skills. The courses included a test of the staff member's knowledge. The managers also provided practical training, such as how to move people safely. They assessed the staff competencies in the work place, including how they supported people with medicines.

The provider had a record of training completed by staff and when updates were due so they could monitor this. They had organised for an external trainer to visit the service and provide food hygiene and other safety training to the staff.

There had been a number of staff group meetings and individual supervision meetings which were recorded. The staff also took part in an annual appraisal where they discussed their work. However, the majority of support and communication between the staff and owners/managers was through informal daily contact. The staff confirmed they were happy with this and felt supported. They said they could discuss any concerns with the managers. The managers were available at all times and the staff said that they gave direction and guidance.

The service was three terrace houses converted into one home. Everyone had their own bedrooms. Some parts of the building could only be accessed by stairs, although there was a passenger lift providing access to most areas. The provider had recently installed additional grab rails in corridors and bathrooms along with modernising some of these rooms, to make them more accessible.

There was a long-term plan for improvements to the environment, some of which had already taken place. For example, the provider had created an area where visitors could make drinks and sit with people if they did not wish to sit in the communal rooms or bedrooms. The provider was also trialling different signage to decide which would be best for the home, to help orientate people. However, some carpets were due to be replaced and some areas of the building needed redecoration.

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 provider had carried out assessments of people's capacity regarding their care and support, although these were not always decision specific. For example, the medicines administration records for some people described them as ''lacking capacity'' to make decisions around medicines. However, the provider had not carried out a specific assessment regarding their ability to understand and consent to medicines administration. We discussed this with the owners. Through our discussions, we found that there had been analysis of people's mental capacity in this area and dialog with their representatives, although this had not always been clearly documented. The provider agreed to make sure this was recorded and kept under review.

People had signed consent to their care plans, or there was evidence that their representatives had been consulted and signed that care was planned in their best interests. People told us that they were involved in making decisions about their care. We observed the staff asking people for consent when they offered assistance, such as providing medicines, or supporting people to move.

The staff monitored people's health and wellbeing and responded to any changes in their health needs. Records of care showed that the staff had acted appropriately in these instances. People's healthcare needs and conditions were recorded in their care plan and there was guidance for staff regarding specific needs, such as how to care for people with diabetes.

People told us that they had access to their GP and other healthcare professionals whenever they needed. Some of their comments included, "If you need to go to the clinic [one of the managers] takes you in the car. They're very good like that", "They ask me so many times if I want to see a doctor, but I'm alright'', ''They take me to the dentist and doctor, sometimes the doctor comes here'' and ''They always accompany us if we have a hospital appointment.'' One relative told us they thought the person's health had improved since they moved to the service because of the care they received. There were detailed records of healthcare interventions and any advice or guidance provided by healthcare professionals. The staff signed to show they had read any updates to care plans which included new healthcare guidance. We saw that the provider had requested medical intervention when they had identified a change in someone's needs, for example, loss of appetite and declining physical health.

People were supported to eat and drink enough to maintain a balanced diet. Three people had their fluid intake monitored. We saw that, whilst the staff recorded fluid intake, they did not add up the total each day on these records, nor did they record the target fluid amount. Therefore, it was not always clear when people were not drinking enough. This had been the case for the preceding few days for two of the people whose fluid intake was being monitored. We found that they had been offered plenty of regular drinks but had only had small amounts each time and this meant they had not drunk enough. We discussed this with the provider who agreed that they would improve the records so that total intake would be recorded each day and any concerns would be easily identified. They also agreed to take action in respect of the two people who had low intake on these days. Following the visit, the provider sent us further information about the action they had taken.

People had access to fresh drinks throughout the day and staff offered these to people. Jugs of water and juice, as well as individual drinks were available. People were offered drinks before, during and after the lunch time meal.

All food was prepared at the service by the chef, or other trained staff when the chef was not working. The provider told us they were looking to increase the number of chefs employed. People's view on food varied and the provider told us they had received some suggestions for improvement about food and were trying to accommodate these. Some of the comments we received included, ''You get meals throughout the day and other snacks…. The food's not bad'', "The food is very nice. Mostly I eat it all, you are offered an alternative if you do not like it'', ''The food could be better, it does not always taste nice and there is not enough, I feel hungry and the sandwiches are tiny'', ''I have a tray of food in my room and they always bring me meals on time'', ''The food is very good, I just eat whatever they give me'', ''You don't get a lot of choice, but I do not mind'', ''You get some odd things which personally I do not like and I just leave'', ''We have a lot of tinned fruit which I like'', ''I have never been offered a cooked breakfast and I would like one'', ''The chef does wonderful soup'' and ''The food is marvellous.''

The provider had completed assessments of people's nutritional needs and these were regularly reviewed. People were weighed monthly and we saw that, where people were identified at nutritional risk, there was a plan for how they should be supported. Referrals had been made to dietitians when people needed this and their guidance had been included in care plans, for example where people needed additional calories.

Good

Is the service caring?

Our findings

People using the service and their visitors told us they liked the staff and had good relationships with them. Some of their comments included, ''They look after me very well'', ''We have the best carers in the world, they pay full attention to you, they are helpful, they come out of nowhere and everywhere'', ''It is very nice here, I do not think you will find any problems, all the staff are nice'', ''They help you the way you want to be helped, they tell me to press the bell if I need them'', ''They couldn't be better'', ''The girls are all pretty good, they are very reliable and you can tell they are interested in what I have to say'', ''They think of the little things, like when I am watching TV they go and get my glasses to give them to me'', ''All the care is pretty good, I haven't got any complaints, the staff are excellent and they really do look after us'', ''When I get a bit bewildered they reassure me'' and ''I think the care is very good, [my relative] is never short of help.''

We observed the staff spending time with people, offering them choices and respecting these. For example, one person told the staff they wanted to remain in their arm chair at lunch time and the staff supported this, some people told the staff they did not want the lunch which was served and they were given an alternative straight away.

The staff respected people's privacy and dignity. They explained what they were doing and made sure care was provided behind closed doors. People told us they were asked if they preferred specific gender care workers.

People were supported to be as independent as they wanted. Some people accessed the community independently, and others were given support from an escort when they needed. One person told us, ''At first when I came here I did not think I could do anything for myself, but the staff encouraged me to try some things and now I am much more independent.'' We observed that people were encouraged to eat their meals independently if they could. One person struggled to keep their food on the plate. We discussed this with the provider, who told us they had also observed this and were in the process of obtaining a plate guard so that the person could remain independent but would find this easier. Following the visit, the provider wrote to us to tell us this equipment was in place.

The provider told us that one person was a retired priest. They explained that they supported the person to help with the Christian service at the home. Other than practicing Christians, there were no people practicing other faiths at the service at the time of our inspection. There were no special requirements, such as specialist meals because of religion or culture.

People told us they had been involved in developing their care plans and that they were able to make choices about how they spent their time, such as when they got up and went to bed. One person said they would like to go out of the house more often. The provider had recently purchased a vehicle and told us they would use this to support people who wanted to access the community. People told us they had been asked for their views on aspects of the service such as activities and food. They said that the provider was available, so they could speak with them and that they felt listened to.

Good

Is the service responsive?

Our findings

People received personalised care which met their needs. They had been involved in the creation and development of their care plans. The provider told us they were in the process of asking people and their relatives to review their care plans to make sure the information was still up to date.

Care plans included information about people's health conditions, mental health needs and social, emotional and communication needs. They were clearly recorded, and the provider undertook monthly updates where they recorded any changes in people's needs and information from healthcare professionals.

The staff kept logs which showed how people had been cared for and activities they had participated in. These showed that people's care plans were being followed.

People told us that their needs were being met. They said that they were well cared for. People were dressed in clean clothes and had access to regular showers and baths. Their hair was clean and they were supported to have this washed and cut when they needed.

There was a range of planned social activities which included some visiting entertainers, church services and large group activities, such as bingo and quizzes. There was also a range of books, magazines, games, crosswords and colouring offered to people to complete individually. We saw that for some periods during the day people were not engaged in activities and had not been offered anything to do. Some people told us they would like more opportunities to go out of the house, or to do different things.

Some people also told us that not all the planned group activities took place. Some of their comments included, ''Half of the activities are not performed'', ''I want to go out more, you can't get out unless a friend takes you'', ''There isn't a lot of entertainment, bingo on a Tuesday but its not a long session, we could do with some other things'', ''There is a lady that does the exercises and you can get chatty and listen to music once a week, but I would like more of that'', ''I don't get bored because there is always someone to talk to but we could do with a little bit more occupation'', ''I listen to the radio and sometime go to the sitting room but there are not entertainments'' and ''The keep fit lady is very good, I am happy here and that is the most important thing.'' We discussed this feedback with the provider. They had already started to increase the number of planned activities and agreed that they would give further consideration to other support they could give people outside of the planned group activities.

People's friends and family were welcome at the home and, those who we met confirmed this. Some of the comments we received included, ''From the moment they open the door when I visit, I feel welcome'', ''Everyone feels very at home here'', ''The staff are all good and make us feel welcome'' and ''It is a really family, community experience here, you are allowed to visit any time and if there is an issue they keep in touch.''

People told us they knew how to make a complaint and they were happy to speak with the providers about

any concerns. The majority of concerns had been dealt with informally and people were satisfied with this process. There was a formal complaints procedure and information about making a complaint had been shared with people and their visitors. The provider had investigated complaints, responded to the complainant and learnt from these so that they could improve the service.

At the time of our inspection, no one was being cared for at the end of their lives. The provider did not offer nursing, so people who became unwell and needed this level of care may not be able to remain living at the service. However, the staff worked closely with GPs and community nurses to make sure they met people's needs as far as possible. Information about people's specific wishes regarding care at the end of their lives and funeral arrangements was recorded or there were details about the people who should be contacted to make these arrangements if needed.

Requires Improvement

Is the service well-led?

Our findings

The provider's processes and systems for identifying risks to people's safety and wellbeing were not always effective. During our inspection visit we identified that cleaning chemicals were not always safely stored and the processes for disposing of clinical waste were not being followed. We also identified errors in the management of medicines, including one medicine which was past the expiry date still in use. These issues and concerns had not been identified by the provider so they could make the necessary improvements.

Furthermore, the provider did not always ensure that staff who were recruited were suitable because they had not carried out thorough checks during their recruitment.

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

When we alerted the provider to the health and safety risks they took immediate action to rectify these. They also told us they had taken action to improve the systems for recruiting staff. The risks were further mitigated by the fact that the provider and members of the provider's family were present at the service, or available on call, throughout the day and night. They worked directly with the staff and monitored their practice.

People told us that they felt the service was well managed. In particular, people liked the fact it was a family run business and felt there was a positive atmosphere there. Some of their comments included, ''This place is well run we are really happy with it'', ''I have nothing but praise for the service'', ''The staff have a good rapport with [people] and always have time to share a few words and a joke'', ''This place is marvellous and they look after me extremely well'' and ''All of the managers are spot on, they have the uncanny ability to choose the right people to be carers.''

The staff told us they felt happy working there and were well supported. They also commented positively about the culture and atmosphere.

There were occasional meetings for people living at the service to discuss how they felt about the service, but more often they had opportunities for informal discussions with the provider. People felt they were able to discuss their concerns or anything they would like changed. There was also a suggestion box for people to write ideas and share these anonymously.

The provider carried out checks on the safety and suitability of the service. They undertook regular audits. They met with an external consultant to discuss the service and how improvements could be made. These meetings were recorded, and we saw evidence of action they had taken to make improvements. In addition, the provider had arranged for an external trainer to offer guidance and support around health and safety issues, including additional training for the staff.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way to service users, because: They had not always done all that was reasonably practicable to mitigate risks. They did not always ensure the proper and safe management of medicines. Regulation 12(1) and (2)(b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems and processes to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others or maintain securely records relating to persons employed in carrying on the regulated activity. Regulation 17(1) and (2)(b) and (d)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that recruitment procedures were operated effectively to ensure persons employed were of

good character or had the qualifications, competence, skills and experience necessary because they had not obtained the required information in respect of each person employed.

Regulation 19(1) and (3)(a), Schedule 3