Solutions (Yorkshire) Limited

Harewood Court Nursing Home

Inspection report

89 Harehills Lane
Chappel Allerton
Leeds
West Yorkshire
LS7 4HA

Tel: 01132269380

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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

This comprehensive unannounced inspection took place on 3 and 10 October 2018.

Harewood Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Harewood Court Nursing Home provides nursing and personal care for a maximum of 40 older people, some of whom are living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with CQC 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 last inspected this service in August 2017. At that time, we found, improvements had been made to the service following our previous inspections when we had identified a number of concerns. We rated the service Requires improvement. We completed this comprehensive inspection to check whether the improvements had been sustained. We found that not all of them had and there were some shortfalls within the service.

On this inspection, the service has been rated as Requires Improvement. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive; we found systems in place to ensure improvements were made and sustained had not been not fully effective.

We found some concerns relating to the records of management of medicines. Although the provider took swift action at the time of the inspection; quality assurance systems had not ensured on-going improvements around medicines management were sustained.

We received mixed views from people who used the service, relatives and staff about staffing levels. This related to the supervision of communal areas and night staffing sufficiency. We have recommended that the provider reviews the deployment and organisation of staff to ensure there are always sufficient staff at the times they are needed.

People were protected from abuse and told us they felt safe. Staff were recruited safely. Risk assessments contained enough detail to enable staff to keep people safe from harm. Risk assessments were reviewed regularly, and any changes were incorporated into people's care plans.

People lived in an environment that was cleaned daily. The home and equipment were maintained to minimise the risk of cross infection. Health and safety checks were undertaken and there were appropriate procedures in place in the event of an emergency.

People told us they enjoyed the food at the service. There was a varied menu available to people and specialist diets were catered for. People were supported to maintain their health. They received consistent care and had access to health professionals as required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to make choices and retain their independence.

Staff felt well supported and received appropriate training which was updated when needed. Staff said they enjoyed working for the service. We were told there was good teamwork and a positive culture within the service.

People we spoke with told us they were happy with the care they received and were complimentary about the staff who supported them. Overall, we saw individualised caring interactions between staff and people who used the service. People were treated with dignity and respect.

People received support from staff that understood their needs and preferences. Care plans were comprehensive to make sure staff had all the information required to support people as they wished. Staff understood how to provide end of life care.

People understood how to complain and these were responded to. People and their relatives had the opportunity to share their feedback.
Staff felt supported by the management team. People, their relatives and staff all spoke highly about the way the service was managed. The registered manager had identified how they wanted to improve the service for people living with dementia and had made positive steps in gaining support to do this.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Concerns relating to the management of medicines were identified at the beginning of the inspection. However, the provider took prompt action to ensure the issues were addressed by the end of the inspection. Evidence of sustained improvement will be checked at our next inspection.

Overall, there were enough staff to meet people's needs but we recommended the provider review deployment and organisation of staff.

Staff were recruited safely and understood what abuse was and how to report it.

Is the service effective?

Good

The service was effective.

Staff told us they received good training and support to carry out their role. Records we looked at confirmed this.

People consented to their care and the service operated within the principles of the Mental Capacity Act 2005 to protect people's rights.

People had enough to eat and drink and had a choice of meals and their health needs were met.

Is the service caring?

Good

The service was caring.

People were supported by caring staff and their privacy and dignity was respected.

Staff were familiar with people's preferences and needs and encouraged people's independence.

People's equality, diversity and human rights needs were met.

Is the service responsive?

Good

The service was responsive.

People who used the service and relatives were involved in decisions about their care and support needs. There was a sensitive approach to the consideration of people's end of life care.

People had access to activities and there were plans in place to develop these further.

People knew how to complain and felt comfortable doing so.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes for assessing and monitoring the quality of the provision were in place. However, these had failed to identify areas of concern in relation to records of medicines management that we found.

The registered manager and staff worked in partnership with other services to help ensure people received effective care.

We received positive comments about the registered manager in relation to how supportive they were and their commitment to improving the service.

Harewood Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 10 October 2018 and was unannounced on both days.

On day one, two adult social care inspectors, a specialist advisor pharmacist and an expert-by-experience carried out the inspection visit. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, two adult social care inspectors continued the inspection visit.

Before the inspection, we reviewed all the information we held about the service including statutory notifications. Statutory notifications, which are a legal requirement, provide the Care Quality Commission (CQC) with information about changes, events or incidents so we have an overview of what is happening at the service. We contacted relevant agencies such as the local authority and clinical commissioning groups, safeguarding and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider had completed a Provider Information Return (PIR) in August 2018. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the visits we looked around the service, spent time in communal areas and observed how people were cared for. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing

care to help us understand the experience of people who could not talk with us.

During the inspection, we spoke with three people who used the service and seven relatives. We spoke with five members of staff, the registered manager, clinical lead and deputy manager.

We spent time looking at documents and records that related to people's care and the management of the service. We looked at six people's care plans and eleven people's medicines records.

Requires Improvement

Is the service safe?

Our findings

We were told people received their medicines on time and were given pain relief if they needed it. One person said, "If I am in pain, I press the button and a nurse sorts me out." However, when we looked at systems in place to manage medicines, we found there were some areas of concern. Two people were prescribed a laxative and the prescriber's instructions had been misinterpreted, which had led to an under dose of this medicine. This did not have any impact on their health. One person missed their morning medicines on the first day of our inspection due to a mis-communication and the person had gone out before taking their medicines.

We reviewed a sample of medicine administration records (MARs) and saw these were overall, completed correctly. However, we noted the actual times of time specific medicines for three people were not recorded and processes were not in place to ensure these types of medicines were given at the required time. This made it difficult to monitor if the necessary time had elapsed before the next dose was administered. Records indicated a person, who was prescribed a nutritional supplement twice daily was given this once daily, as the MAR had not been completed correctly. Although, staff did say they administered this twice daily as prescribed. A handwritten entry for a blood thinning medicine had not been completed in line with best practice. There was a lack of detailed guidance for staff when administering 'as required' and covert (without a person's knowledge) medicines; this needed to be more personalised. Staff we spoke with were able to describe how and why these medicines were administered.

Medicines were ordered when needed and stored safely. We looked at the records and management of controlled drugs (CD's). CD's are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found improvements to the records of when CD's were received, destroyed and returned to the pharmacist needed to be more robust to ensure best practice.

At the end of the first day of our inspection, we spoke with the registered manager and clinical lead about our concerns. When we returned to the service seven days later, we found they had responded to all of these concerns and implemented actions to resolve the issues. we identified. We judged these actions would have a positive impact on the safe management of medicines. We will review this again at our next inspection to ensure these positive changes have been sustained.

There were mixed views from people who used the service and their relatives as to whether there were enough staff. People and their relatives told us their or their family member's needs were met, but staff were busy. One relative said staff were, "Run off their feet." We saw there were short periods during the day when staff were unavailable in the communal lounges. Two people's relatives also raised concerns that the lounges were not always supervised and there could be a risk of falls. The registered manager and staff said they aimed to maintain a presence in communal areas but this was not always possible. One staff member said, "During the day we should always have one member of staff in main areas, where most people are, but sometimes it's hard." Our observations showed call bells were answered in a timely manner and people were responded to well if they asked for any assistance.

The provider's dependency tool showed they had assessed there to be sufficient staff for the number of people at the service. Staff told us there were enough staff to meet people's needs through the day. Rotas indicated there was one nurse and at least six carers; one of whom was a senior carer, on duty throughout the day. They were also supported by ancillary staff. Some days an additional shift had been introduced to cover busier times such as early mornings and evenings. The registered manager planned to introduce this shift permanently, once they had recruited to these posts.

At night there was one nurse and two carers or an on-call nurse and three carers. We were told the on-call nurse was in the building or an adjacent building and could respond swiftly if needed. One member of staff told us it was difficult when there was only an on-call nurse. They said more staff were needed as the on-call nurse was not available to assist with general tasks and this could leave a floor unstaffed at times. We saw regular agency nurses were used to cover some night shifts due to vacant posts the registered manager was trying to fill.

We recommend the provider reviews the deployment and organisation of staff to ensure there are always sufficient staff at the times they are needed.

People and their relatives thought the service was a safe place to live. Their comments included; "I am safe because the staff work to look after me", "I am as safe as I can be", "[Person's name] is watched over and they adhere to needs" and "[person's name] is safe here, [name] has equipment to keep [name] safe." People's care plans showed assessments, which identified areas of risk and documented strategies to manage the risks to people. This included all aspects of people's lives such as their health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed.

There were effective recruitment and selection processes in place. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. Staff demonstrated their understanding of safeguarding procedures to ensure people were protected from any harm. Staff told us they would have no hesitation in reporting safeguarding concerns and they described the process to follow and were aware of the provider's whistleblowing procedure. .

The premises were overall safe, clean and well maintained. Records confirmed checks of the building and equipment were carried out to ensure health and safety. Infection control and prevention checks were carried out and staff had received training that was reflected in their working practices. There was a good stock of personal protective equipment, including gloves and aprons. There were no offensive odours but we detected some subtle stale smells in areas of the service with older carpets. The service had a maintenance list of things to be fixed. We mentioned to the registered manager some items that required attention and found most of the concerns were noted to be fixed already. People who used the service and their relatives told us they had no concerns about cleanliness in the service.

The registered manager monitored accidents, incidents and safeguarding concerns to identify trends and make improvements where mistakes had happened. We saw actions were completed because of the incidents log. For example, two people had experienced falls and movement sensors for chairs were now in place.

Good

Is the service effective?

Our findings

People told us they were satisfied with the standard of care and support received. Comments we received included; "No matter what you ask them they know, they (staff) will get me what I want and need. They know what to do to wash me and how to keep me clean", "The staff do know how to look after [person's name]" and "Staff know what to do; they look after [person's name] fine."

Induction training was tailored to meet the needs of individual staff members and related to their level of experience or previous training. New staff completed the registered provider's own induction programme. The provider was not using the Care Certificate which is the agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. However, the registered manager said they had plans to introduce this in the future. There was a rolling programme of training available to staff. Topics included; safeguarding, moving and handling, dementia, person centred care and fire safety. Training was refreshed to ensure staff's skills remained up to date. Some refresher training was overdue for some staff. The registered manager was aware of this and had an action plan in place to ensure this would be completed. Specialist training had also been completed by some staff; this included recognition of sepsis and end of life care.

Staff told us they felt well supported in their role and received the training they needed to carry out their role. There was a programme of staff supervision in place. Supervisions were held on a one to one basis or as group meetings with their supervisor. Staff told us they received supervision and records showed supervisions were held regularly. Annual appraisals were also completed with staff to enable them to discuss their development needs.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if a person's needs could be met. Where people lacked capacity and it had been assessed that restrictions amounted to a deprivation of liberty, appropriate DoLS applications had been made. The registered manager had a good understanding of the MCA legislation and staff received training to enhance their understanding. People were asked consent before care and support was provided. Where people lacked capacity best interest decisions had been made involving families and relevant people.

The environment of the service was appropriate to meet people's needs and there was enough communal space available for people to be able to sit quietly or join in activities. Signage was in place to assist people to find their way around. The registered manager completed audits on the quality of support for people living with dementia. They said they had identified initiatives such as new flooring and were planning to create a more stimulating environment for people.

People told us their day to day health needs were met and they had access to healthcare professionals when needed. We saw a range of health professionals were involved in people's care. Where people were at risk from pressure damage, steps had been taken to support them in a way that would reduce the risk of pressure ulcers. We saw examples where people had been referred to a health care professional following the deterioration of a pressure area. We also saw one person's skin damage had much improved with the support of staff. The provider had signed up to a national campaign to prevent pressure ulcers 'React to Red Skin' and the deputy manager of the service had undertaken training to raise awareness of this.

People had enough to eat and drink and maintain a well-balanced diet. People's weights were monitored and action was taken if people were losing weight or nutritionally at risk. Menus showed a variety of food was on offer to people. Feedback on food was positive with menu choices offered and special diets catered for. People's cultural needs were also met, for example one person was vegetarian. People told us, "There is something for everybody. I get a choice" and "It's okay, I can have what I want and I get enough to drink." We saw the menu was on display in the service and this also included a snacks options menu. The registered manager told us they had regular themed food events and a Caribbean food day was currently being planned.

We observed the lunch time meal in both the dining rooms of the service. Overall, mealtimes were a positive experience for people. Everyone was asked what they would like and a choice was also given. Some people were not able to make a choice from being told what was on offer. We did not see anyone was shown a plated meal to assist them in making choices. The registered manager said they would look at introducing this. Most people were given the support they needed to eat their meals. One person was supported with their meal, however there was very little communication from the member of staff supporting them. Another person did not eat their meal and although was encouraged to do so, their meal had gone cold in the time it was sat in front of them. The registered manager said they would raise this with staff to ensure an improved experience for people.

Good

Is the service caring?

Our findings

People we spoke with thought the staff were very caring and helpful and support was always there for them. One person said, "They treat me well." A person's relative said, "All [staff] are kind and polite speak to [person's name] softly and with respect." Another relative said, "I have no concerns about the behaviour of the staff. They are polite and kind and talk to her in a quiet tone." A third relative said, "Staff have always been kind and polite." People looked comfortable engaging with the staff. They maintained good eye contact and were smiling and chatty with staff.

People looked well cared for, which is achieved through good standards of care. Staff were confident people received a high standard of care and felt proud to deliver such care. Staff told us they would be happy for a family member to receive care in the service. One staff member told us their positive experience of this. One relative said they thought personal care standards could be improved for their relative. We passed this on to the registered manager for them to address. Staff spoke warmly about people who used the service; it was clear they had developed positive relationships with people and valued them as individuals. People were encouraged to maintain their independence. For example, to support themselves when eating and drinking and to walk with walking aids or assistance.

People confirmed their privacy and dignity was always respected. They told us staff knocked on their doors before entering their rooms and their care was carried out in private with doors and curtains closed. A relative said, "They always close curtains and doors when doing personal care." We saw some people were cared for or chose to spend their time in their own rooms. Staff told us some people would prefer their bedroom doors left open but were not able to do so as the door guards linked to the fire alarm had been removed. The registered manager said they would review this to ensure people had a choice in this matter.

Interactions between staff and people who used the service were overall, friendly and caring. We saw good examples of person centred care. For example, one person was falling to one side in their wheel chair; staff saw this and acted straight away. They spoke kindly to the person and explained what they needed to do to make the person more comfortable. On another occasion a person was distressed and shouting and this caused another person to feel angry. Staff intervened and explained the situation calmly and quietly to both parties to try and resolve the problem. This calmed both people. However, on one occasion we saw a person was not responded to well when they were shouting out; the reason for their distress was not explored by the staff member. We raised this with the registered manager who told us they would address this with staff.

People were protected from discrimination and were supported in any cultural support they required as part of their package of care. For example, we saw people's preferences and cultural background and faith were identified during the initial assessment. This enabled staff to become aware of what was important to a person and support them with this. One person had regular contact with their church. Another person was supported at times by staff that spoke their preferred language and had their radio tuned in to a radio station with programmes in their preferred language.

People told us they were consulted with, listened to and made decisions about their support. One person

said, "I tell them if I don't want my morning shower so they will give me a wash down instead." People's relatives also told us their family members could make their own choices about how care was delivered. One relative told us, "[Person's name] likes to sleep in, so often has their breakfast late. Staff ensure [person's name] gets their breakfast whenever they want." We saw staff did not rush people and gave people time to make choices.

People's relatives told us they were involved in developing their family member's care plan. One relative said, "My [family member] looks after their care plan [family member] does discuss it with staff. If we are unhappy we can discuss it and we are listened to." Another relative said, "I help with the decisions about their care."

The registered manager was aware of how to assist people to obtain the services of an advocate if needed. We also saw there was information on display in the home regarding local advocacy services that people could access.

Good

Is the service responsive?

Our findings

Records showed people had their needs assessed before they moved into the service. This ensured the service could meet the needs of people they were planning to admit. Following an initial assessment, care plans were developed, detailing the care needs and support people needed to ensure personalised and responsive care was provided. The registered manager spoke of the importance of ensuring a thorough assessment prior to offering people a place at the service.

Care plans focussed on people as individuals and documented people's life history. They included people's interests and were added to by staff when new information became available. People agreed their goals with staff and their needs were regularly reviewed and, re-assessed with them. Care plans were then updated to ensure any change in needs continued to be met. However, we found care plans on the safe administration of medicines was not always documented in sufficient detail. For example, one person who received covert medicines did not have this mentioned in their care plan. The registered manager and clinical lead took prompt action to review and update these. We saw on the second day of our inspection; detailed care plans were in place regarding the support people needed with their medicines. Daily notes confirmed that care was delivered as planned and identified activities took place. People were encouraged to take ownership of their care plans and contribute to them when they wished.

Some people had end of life care plans in place so staff could support people in their final days and their preferences would be respected. The registered manager told us they worked with other agencies, such as district nurses, to provide end of life care when this was needed. Staff spoke with sensitivity when speaking about end of life care. One staff member told us they felt saddened when people passed away as they developed relationships with people.

We received a mixed response about activity levels in the service. Some people thought there was enough to do and they got involved in activities they were interested in. People's relatives, overall, thought activities were interesting and provided their family members with stimulation. Their comments included; "Think there is an activity every day for people", "[Person's name] gets involved when they want to" and "[Person's name] liked the singer today." One person's relative said, "It would be nice in the summer if people could go out in the garden more."

On the first day of our visit, there was a singer to entertain people. Fourteen people and two staff attended. Most people joined in the tunes and staff encouraged people to sing and sway with the music. The songs were a popular choice and most people knew the words. Everyone looked like they were enjoying themselves; smiling and singing along. The registered manager told us they were currently in the process of recruiting an activity organiser and we saw evidence of this. In the PIR, the registered manager stated, 'Special events such as Easter, birthdays, Christmas and Eid are celebrated and families are welcome.' The registered manager also told us of the regular bible reading events that took place in the service and the visits from the New Testament Church Choir which enabled people to worship and sing together.

People and their relatives understood how to make a complaint. People and their relatives told us if they

had concerns they believed these would be addressed. Comments we received included; "I would go to the head person and say I would like something doing about this" and "I would report anything I didn't like to staff." There was a complaints policy in place: where
complaints had been received, these had been investigated and a response provided in line with the policy. Two people's relatives described their experience of raising concerns. They told us they were satisfied with the response and outcome. One relative said, "I complained and they sorted it out."

The provider had policies in place in relation to protected characteristics under the Equality Act 2010. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

The registered manager was aware of the Accessible Information Standard. This is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager was aware of how to access translation services and had produced some information such as menus with pictures to support people's understanding.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and provider completed a variety of audits to assess the quality of the service provided. This included audits known as a 'random drug audits'. This meant checks were carried out on 12 people's medicines weekly. No recent issues had been identified. This audit had not included checks on storage, cleanliness, administration practice, expiry dates, storage and temperatures checks. The audits or safe medicines practice had not identified the areas of concern we raised during this inspection regarding PRN (as and when necessary medicines) protocols, time specific medicine records, controlled drugs records and the misinterpretation of instructions for some medicines.

This was a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A 'Safe and secure handling of medicines audit' was completed annually by a pharmacist. We looked at the last report dated May 2018 and found a detailed overview of the whole medicines process. This included areas such as disposal of medicines, health and safety, ordering, storage and CD's. This audit identified areas to improve, for example medicine room temperatures to be monitored and recorded. We saw this action had been completed.

Care plan audits were carried out monthly and any identified shortfalls were recorded. An infection control audit was completed six monthly. Most recent audits identified areas for improvements. For example, the kitchenette areas needed redecoration. Other checks completed included the equipment in place, personal protective equipment, laundry, storage and clinical areas. The registered manager maintained and developed an overall action plan for the service. This contained the results and actions from all audits in the service and any provider or senior management visits. The registered manager told us this was an on-going action plan to support continuous improvement in the service and had identified dates for when outcomes were expected to be achieved. The registered manager told us they discussed this action plan on a regular basis with the provider to ensure they maintained an overview of the service.

People who used the service and their relatives told us the service was well-managed. One person said, "[Registered manager's name] is lovely, I really like them." One relative commented, "I don't know the managers name but I know who they are and they know who I am. It is well run; when I come to visit I am always made to feel welcome." Another relative said, "I think they [the registered manager] do a good job; a good standard." We saw the registered manager made time to speak with people in the service and it was clear people recognised them and felt able to approach them. The registered manager was knowledgeable about the service they managed. They knew everyone well and could answer questions on people's care. We also found clinical staff equally knowledgeable. We found there was a positive culture of openness, and recognition of where improvements were needed within the service.

Staff said they felt fully supported by the registered manager and provider. One staff member said, "Yes, I feel supported, I have meetings and team meetings. We have chance for training and are asked how we are doing; what weaknesses we have and discuss how we can improve." Another staff member said, "Plenty of

team meetings; again useful to share information. I feel supported and we help each other." We saw staff meetings took place where staff could contribute ideas or raise any suggestions they may have. It was clear staff were kept informed of any changes and important issues that affected the service.

People who used the service and relatives were asked to provide feedback on the service. Quality assurance surveys were sent out and the results from the latest survey completed in February 2018 showed a high degree of satisfaction with the service. The results were published in the service and showed action taken to address any suggestions made. For example, more involvement in care planning had been requested and acted upon.

'Resident and relatives' meetings took place. The registered manager said they did not get good attendance at these meetings. Some relatives told us the meetings were not at a time convenient to them. The registered manager told us they had tried different times to encourage better attendance and would review this again to afford people more opportunity to attend.

The registered manager was aware of their responsibilities to report accidents, incidents and other notifiable events that occurred within the service to the Care Quality Commission so that any action needed could be taken. The registered manager was supported in their role by an operational manager and the provider. The registered manager worked in partnership with other agencies when required, for example healthcare professionals, the local authority and social workers. This had led to the introduction of a weekly surgery from a GP to improve the health and wellbeing of people who used the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a fully effective system to monitor and improve the quality and safety of the service delivered to people. Some medication records were not always accurate or an accurate and contemporaneous record of people's needs.