Mr M S Kelley

Amberleigh Manor

Inspection report

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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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Amberleigh Manor on 14 October 2015. This was an unannounced inspection. The service was registered to provide accommodation and care, including nursing care for up to 40 older people, with a range of medical and age related conditions, including arthritis, frailty, mobility issues, diabetes and dementia. On the day of our inspection there were 17 people living in the care home.

At our last inspection on 8 and 14 October 2014 the service was found to be non-compliant in areas relating to safeguarding people, staffing levels and infection control. This represented breaches of Regulations 13, 18 and 15, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection, the provider told us what action they were going to take. At this inspection we found that improvements had been made, however there were still some areas we considered still required improvement. This represented a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

Summary of findings

A registered manager was in post, but was unable to be present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In the absence of the registered manager, a newly appointed business manager was present throughout the inspection.

We considered further improvements were required in several areas throughout the home, relating to cleanliness and infection control. There was also a lack of stimulation and meaningful, person-centred activities, which put people at risk of social isolation. Failing to identify these areas of concern also demonstrated shortfalls regarding the management of the service.

During our inspection, we observed that people were happy and relaxed with staff. and comfortable in their surroundings and One person told us, "I think we are looked after very well." Another person told us, "Yes, we do feel safe, staff make sure that we are well looked after."

People received care and support from staff who were appropriately trained and confident to meet their individual needs and they were able to access health, social and medical care, as required. There were opportunities for additional training specific to the needs of the service, such as diabetes management and the care of people with dementia. Staff received one-to-one supervision meetings with their manager Formal personal development plans, such as annual appraisals, were in place.

People's needs were assessed and their care plans provided staff with clear guidance about how they wanted their individual needs met. Care plans were person centred and contained appropriate risk assessments. They were regularly reviewed and amended as necessary to ensure they reflected people's changing support needs.

There were policies and procedures in place to keep people safe and there were sufficient staff on duty to meet people's needs. Staff told us they had completed training in safe working practices. We saw people were supported with patience, consideration and kindness and their privacy and dignity was respected.

Safe recruitment procedures were followed and appropriate pre-employment checks had been made including evidence of identity and satisfactory written references. Appropriate checks were also undertaken to ensure new staff were safe to work within the care sector.

Medicines were managed safely in accordance with current regulations and guidance by staff who had received appropriate training to help ensure safe practice. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

People were supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and records were accurately maintained to ensure people were protected from risks associated with eating and drinking. Where risks to people had been identified, these had been appropriately monitored and referrals made to relevant professionals, where necessary.

There was a formal complaints process in place. People were encouraged and supported to express their views about their care and staff were responsive to their comments. Satisfaction questionnaires were used to obtain the views of people who lived in the home, their relatives and other stakeholders.

We found two 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 this 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?
The service was not always safe.

Standards of cleanliness and infection control practices were inconsistent.

People were protected by robust recruitment practices, which helped ensure their safety. Staffing numbers were sufficient to ensure people received a safe level of care.

Medicines were stored and administered safely and accurate records were maintained.

Requires improvement

Is the service effective?
The service was effective.

People received effective care from staff who had the knowledge and skills to carry out their roles and responsibilities.

Staff had training in relation to the Mental Capacity Act (MCA) and had an understanding of the Deprivation of Liberty Safeguards (DoLS). Capacity assessments were completed for people, as needed, to ensure their rights were protected.

People were able to access external health and social care services, as required.

Good

Is the service caring?
The service was caring.

People and their relatives spoke positively about the kind and compassionate attitude of the care staff.

Staff spent time with people, communicated patiently and effectively and treated them with dignity and respect.

People were involved in making decisions about their care. They were regularly asked about their choices and individual preferences and these were reflected in the personalised care and support they received.

Good

Is the service responsive?
The service was not always responsive.

Staff had a good understanding of people's care needs, however there was a lack of stimulation and people were not supported to engage in personal interests and preferences.

Individual support needs were regularly assessed and monitored, to ensure that any changes were accurately reflected in the care and treatment people received.

Requires improvement

Summary of findings

A complaints procedure was in place and people told us that they felt able to raise any issues or concerns.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Quality monitoring audits had not identified areas of concern relating to cleanliness, infection control and social stimulation.

Staff said they felt valued and supported by the registered manager. They were aware of their responsibilities and felt confident in their individual roles.

There was a positive, open and inclusive culture throughout the service and staff shared and demonstrated values that included honesty, compassion, safety and respect.

Amberleigh Manor

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.

The inspection took place on 14 October 2015 and was unannounced. The inspection team consisted of two 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. The expert by experience had experience of a range of care services for older people.

Before the inspection we looked at information we held regarding the service, including notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with four people who lived in the home, three relatives, three care workers, the cook and the business manager. Throughout the day, we observed care practice, the administration of medicines as well as general interactions between the people and staff.

We looked at documentation, including four people's care and support plans, their health records, risk assessments and daily notes. We also looked at three staff files and records relating to the management of the service. They included audits such as medicine administration and maintenance of the environment, staff rotas, training records and policies and procedures.

Requires improvement

Is the service safe?

Our findings

We had concerns about the cleanliness of the premises, the poorly maintained furniture and furnishings and the inconsistent infection control procedures. In the entrance hall here was an unpleasant odour and throughout the premises we saw windows were dirty, inside and out; chairs and side tables in the lounge were stained, scratched and dusty and carpets on the first floor were threadbare. The lack of cleaning and maintenance at Amberleigh Manor was effectively summed up by an experienced member of staff who told us, "This place just needs someone to love it."

There was only one cleaner on shift during our inspection. They told us that if someone was off sick they were responsible for cleaning the home and for undertaking all the days' laundry tasks. Cleaning shifts were 9.30am until 1.30pm. We were informed that completing the laundry took at least the first two hours of this time. This clearly had an impact on the level of cleanliness throughout the home.

We discussed with the cleaner about how they would deal with spillages, including bodily fluids. They showed us the carpet cleaner and informed us that they would shampoo the affected area. However no written information was available regarding cleaning and decontamination schedules to be followed, which had resulted in inconsistent cleaning and infection control procedures. We asked how often the carpet cleaner itself was cleaned; as the bottom of the machine, where the clean and dirty water flowed, was encased in dust and dirt. We were informed that there was no regime for the cleaning and decontamination of this part of the machine. When this was brought to the attention of the business manager, they immediately asked the maintenance man to attend to it, as a priority. They also assured us that, from now on, this would be included in the revised cleaning and maintenance schedule.

We saw that the cleaner's trolley was dusty and asked how often it was cleaned. We were told that there was no rota in place for the cleaning of the trolley. The trolley which was taken around all areas of the home was stored in the same room where care staff washed and disinfected commode pans and bed pans. We also found that clean mop heads were being stored in this area, along with the carpet cleaning machine. This posed a potential risk of cross infection and was an area that we considered required improvement.

The laundry room contained large industrial washing and drying machines, however the room itself was untidy, with brushes used for dusting the back of the drying machines stacked full of dust next to the sink. The piping to the taps above the sink was covered in insulation which had been painted over. This meant that the surface of the insulation cracked under touch and could not be effectively decontaminated.

We reviewed the cleaning schedules which were in place for each room with the areas to be cleaned identified. Staff completed the form each day when they had cleaned the room. We reviewed the rotas and specifically the rotas for the cleaning of two rooms between the beginning of June 2015 and the 21st September 2015. We found that areas such as the bed frame, mattress and bed sides had not been marked as having been cleaned for all of this time. This meant that people were at potential risk of cross infection.

In line with current guidance and legislation, premises and equipment must be clean, well maintained, and free of odours that are offensive or unpleasant. The provider should monitor standards of cleanliness throughout the home and take immediate action to address identified shortfalls. The poor levels of cleanliness and infection control constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with said they felt safe living in the home. They had no concerns and had never felt unsafe at any time. One person told us, "I think it is pretty safe, and haven't found any difficulties at all. I think we are looked after very well. " Another person told us, "Yes, staff make sure that we are well looked after and I do feel safe here." Relatives told me that they had no cause for concerns with regards to the safe wellbeing of their family members. One relative told us, "I've never had any worries or concerns."

There were generally enough staff to meet people's care and support needs in a safe and consistent manner. The business manager told us that staffing levels were regularly monitored and were flexible to ensure they reflected current dependency levels. They confirmed that staffing

Requires improvement

Is the service safe?

levels were also reassessed whenever an individual's condition or care and support needs changed, to ensure people's safety and welfare. This was supported by duty rotas that we were shown. Throughout the day we observed positive and friendly interactions. People were comfortable and relaxed with staff, happily asking for help when they needed it.

However, people told us that it was not always relaxed. During the evenings, they often had to wait for assistance, sometimes for unacceptably long periods of time. One person told us, "At night, I sometimes ring my bell and they come quite quickly but once I asked to go to the toilet at about 7.30pm and it was 9pm before anyone came." Another person told us, "It varies, mostly at night when I have to wait for them to help me. I think they have a lot to do and maybe sometimes there are not enough of them and at times they are run off their feet." This was reinforced by a relative, who told us, "Sometimes there is a problem for instance when someone needs the toilet." A member of staff told us that due to declining numbers of residents, the care hours have been reduced which in turn has had a, "Direct impact on the care residents are receiving."

Medicines are managed safely and consistently. We found evidence that staff involved in administering medicines had received appropriate training. A list of staff authorised to undertake this was kept with the medicines folder. We spoke with the business manager regarding the policies and procedures for the storage, administration and disposal of medicines. We also observed medicines being administered. We saw the medication administration records (MAR) for people who used the service had been correctly completed by staff when they gave people their medicines. We also saw the MAR charts had been appropriately completed to show the date and time that people had received medicines at times that varied, depending on when they were needed.

People were protected from avoidable harm as staff had received relevant training. They had a good understanding of what constituted abuse and were aware of their responsibilities in relation to reporting such abuse. Staff told us that because of their training they were far more aware of the different forms of abuse and were able to describe them to us. Records showed that all staff had completed training in safeguarding adults and received regular training updates. This was supported by training records we were shown. Staff also told us they would not hesitate to report any concerns they had about care practice and were confident any such concerns would be taken seriously and acted upon.

The provider operated a safe and robust recruitment procedure and we looked at a sample of three staff files, including recruitment records. We found appropriate procedures had been followed, including application forms with full employment history, relevant experience information, eligibility to work and reference checks. Before staff were employed, the provider requested criminal records checks through the Government's Disclosure and Barring Service (DBS) as part of the recruitment process. The DBS helps employers ensure that people they recruit are suitable to work with vulnerable people who use care and support services.

There were arrangements in place to deal with emergencies. Contingency plans were in place in the event of an unforeseen emergency, such as a fire. We saw the home was well maintained, which also contributed to people's safety. Maintenance and servicing records were kept up to date for the premises and utilities, including water, gas and electricity. Maintenance records showed that equipment, such as fire alarms, extinguishers, mobile hoists, the call bell system and emergency lighting were regularly checked and serviced in accordance with the manufacturer's guidelines.

Good

Is the service effective?

Our findings

The service ensured the needs of people were consistently met by competent staff who were sufficiently trained and experienced to meet people's needs effectively. People and relatives spoke positively about the service and told us they had no concerns about the care and support provided. One person told us, "It is quite nice living here. We have our own room that we can go to when we want to and the staff make sure that we are well looked after." Another person told us, "I think they do their upmost to look after us in the way we wish." Relatives said they felt that staff knew their loved ones well and were able to meet their needs. One relative told us, "My father's always clean, shaven and has his feet and nails attended to on a regular basis."

People also confirmed they were asked about their likes, dislikes and preferences. One person told us, "We were both asked about our likes and dislikes and about how we wish to be treated. We are very pleased with the care we receive." Another person told us, "I think you can go to bed when you like."

Staff said they had received an effective induction programme, which included getting to know the home's policies and procedures and daily routines. They also spent time shadowing more experienced colleagues, until they were deemed competent and felt confident to work unsupervised. One member of staff told us, "Training is obviously important and there's certainly plenty of it."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the business manager was aware of the process and fully understood when an application should be made and how to submit one. Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. The business manager told us that to ensure the service acted in people's best interests, they maintained regular contact with social workers, health professionals, relatives and advocates. Following individual assessments, the registered manager had made DoLS applications to the local authority, as necessary, and was waiting for decisions regarding authorisation.

Staff had received training on the MCA and DoLS and understood the importance of acting in a person's best interests and protecting their rights. They were aware of the need to involve others in decisions when people lacked the capacity to make a decision for themselves. This ensured that any decisions made on behalf of a person who lived at the home would be made in their best interests. Staff also described how they carefully explained a specific task or procedure and gained consent from the individual before carrying out any personal care tasks. People confirmed care staff always gained their consent before carrying out any tasks.

The kitchen was well ordered, and appeared clean and tidy. The cook showed us the planned menus. A new menu plan had just been started. This had come over from another of the provider's homes which was nearby. The cook was in the process of adapting the new menu to suit the people who lived at the home. They explained that it was time consuming working with the new menu because of the adaptions. The menu showed that a choice of hot and cold meals was available for people and the cook said that they always prepared alternative meals if people did not want to eat what was on the menu. The cook described how pureed food was presented in individual sections, so as to be "more appetising". They were clearly aware of people's individual preferences. They told us they visited people each day to discuss what they wished to eat, and confirmed that the care team provided clear information as to people's special dietary requirements. Although the cooks were aware of people's nutritional requirements, there was no written guidance or information in place about specific diets. Some concerns were raised regarding the expectations put on the kitchen staff who we were told were, "Worn out". Although they did not have an assistant, they said they were expected, "To do everything", including the cleaning, dealing with deliveries and preparing food for the afternoon and evening, as their shifts ended at 2pm.

We observed lunchtime in the dining room, which was undergoing refurbishment. On the day of our inspection there were no curtains up and the walls and furnishings were basic, bare and bland. Tables were set with a variety of different table clothes and drinks were served in yellow plastic beakers. People were seated by 12.15pm and those who were able to eat independently were given their meals straight away. However there were not enough staff available to assist individuals, who required support with eating, in a timely manner. Some people were left waiting

Good

Is the service effective?

for unacceptable lengths of time before being assisted, which meant that some did not finish their lunch until 2pm. After lunch, we spoke with five people, who all said they had enjoyed their meal. One person told us, "The food here is very nice and it is to my liking. We always have two choices and it has always been pretty fair, I can't grumble." Another person told us, "The food is quite good. I really enjoyed my dinner today." The situation with insufficient staff during lunchtime was discussed later with the business manager, who acknowledged the impact on people and assured us that this would be addressed as a matter of urgency.

People were supported to maintain good health. A senior care worker confirmed that a local GP visited Amberleigh Manor on a regular basis to hold a weekly clinic. Visiting chiropodists and district nurses were also involved in people's care and treatment. One district nurse who we spoke with said they had been coming to the home for over three years and had seen recent improvements in the physical environment, with several rooms being painted and decorated and new furniture provided. They told us, "The staff here work cooperatively with us and always follow any recommendations we make. They also always escort us around the building but I'm aware sometimes that they leave people in the lounges unsupervised."

People and their relatives told us they were happy regarding the availability of health professionals, when necessary. Care records confirmed that people had regular access to healthcare professionals, such as GPs, speech and language therapists, podiatrists and dentists. We saw that, where appropriate, people were supported to attend some health appointments in the community. Individual care plans contained records of all such appointments as well as any visits from healthcare professionals.

Good

Is the service caring?

Our findings

We received positive feedback from people and their relatives regarding the kind and compassionate nature of the staff. They told us they had the opportunity to be involved in individual care planning and staff treated people with kindness, dignity and respect. One person told us, “The staff here are very good to me. They treat us with respect and we like it.” Another person told us, “They always knock on the door before entering. They listen to me and are very good and very kind.”

Relatives were clearly satisfied with the care and support provided and spoke positively about the kindness of the staff and the atmosphere within the home, which they described as, “Lovely and friendly.” One relative told us, “People here are well looked after and the staff seem to cope well with any situation.” Another relative described the importance of routine and person centred care. They told us, “Each person has their own routines and the care and support they get seems to be arranged around their preferences and what they like.”

Throughout the day we observed staff to be helpful, compassionate and caring in their dealings with people. We saw and heard staff speak with and respond to people in a calm, considerate and respectful manner. They called people by their preferred names, patiently waited for and listened to the response and checked that the person had heard and understood what they were saying. Their conversations with people were not just task related and we saw them regularly check out understanding with people rather than just assuming consent. We also saw staff knocking on people’s doors and waiting before entering. In other examples of the consideration and respect people received, we saw that people wore clothing that was clean and appropriate for the time of year and they were dressed in a way that maintained their dignity.

The business manager and staff demonstrated a commitment to providing compassionate care. They told us people were treated as individuals and supported and enabled to be as independent as they wanted to be. A member of staff told us that people were encouraged to take decisions and make choices about all aspects of daily living and these choices were respected.

Communication between staff and the people they supported was sensitive and respectful and we saw people being gently encouraged to express their views. We observed that staff involved people, as far as practicable, in making decisions about their personal care and support. Relatives confirmed that, where appropriate, they were involved in their care planning and had the opportunity to attend reviews. They said they were kept well-informed and were made welcome whenever they visited.

We saw people’s wishes in respect of their religious and cultural needs were respected by staff who supported them. Within individual care plans, we also saw personal and sensitive end of life plans, which were written in the first person and clearly showed the person’s involvement in them. They included details of their religion, their next of kin or advocate, where they wished to spend their final days and what sort of funeral they wanted.

Requires improvement

Is the service responsive?

Our findings

People and relatives we spoke with were largely unimpressed with the lack of stimulation or any meaningful activities. A member of staff said that for the last three months there had been no activities coordinator, as the previous one had left and not been replaced. They told us that care staff were initially expected to provide entertainment and activities for people but this had proved impossible due to their increasing dependency levels. During our inspection we observed that staff appeared to have little time to spend sitting and talking with people, other than task related interaction, and saw very little evidence that any meaningful activities were provided

During our inspection we received some negative feedback about the lack of stimulation in the home. One person told us, "It is alright here but I am just sat around, I would like something to do." This was reflected in other comments we received. One person told us, "We just sit in here all day; sometimes staff come and talk to me." Another person said, "I choose to sit in the lounge all day because there is nothing else to do." Similar comments were received from relatives we spoke with. One relative told us, "They don't seem to do much at all and there are no activities, because staff don't have the time."

Meaningful interaction and stimulating activities for people provide an important element in improving their quality of life. Having companionship and someone to talk with helps people maintain their mental and physical wellbeing, and is an integral part of providing person centred care. People did not receive support that reflected their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that requires improvement.

Staff emphasised the importance of knowing and understanding people's individual care and support needs so they could respond appropriately and consistently to meet those needs. Throughout the day we observed friendly, good natured conversations between people and individual members of staff. However, staff seemed only to speak and interact with people when providing care. .We looked at a sample of files relating to the assessment and care planning for four people. Each care plan had been developed from the individual assessment of their identified needs. We saw that people were assessed before they moved into the service, to ensure their identified needs could be met.

Care plans were personalised to reflect people's wishes, preferences, goals and what was important to them. They contained details of their personal history, interests and guidelines for staff regarding how they wanted their personal care and support provided. However we found that care plans were disorganised and lacked structure, including any index or dividers, making it difficult to access specific information. These issues were discussed with a senior care worker who acknowledged the care plans could be more concise, so making information more readily accessible.

Staff worked closely with individuals to help ensure that their care, treatment and support was personalised and reflected their assessed needs and identified preferences. People told us they were happy and comfortable with their rooms and we saw rooms were personalised with their individual possessions, including small items of furniture, photographs and memorabilia. People told us they felt listened to and spoke of staff knowing them well and being aware of their preferences, likes and dislikes.

People and their relatives told us they were satisfied with the service. Some knew how to make a complaint if necessary and felt confident that any issues or concerns they might need to raise would be listened to, acted upon and dealt with appropriately. However we spoke to one relative who, although they had no concerns, were not aware of the complaints procedure. They told us, "No, we would not know where to start or who we would talk to. We have never had any cause for any concerns although [my relative] would not be able to express [themselves] or tell us if there was anything wrong."

Records indicated that comments, compliments and complaints were monitored and acted upon and we saw complaints had been handled and responded to appropriately and any changes and learning recorded. For example, we saw that, following a concern raised by a relative, a person had their care plan reviewed and their support guidelines amended. Staff told us that, where necessary, they supported people to raise and discuss any concerns they might have. The business manager told us

Requires improvement

Is the service responsive?

they welcomed people's views about the service. They said any concerns or complaints would be taken seriously and dealt with quickly and efficiently, ensuring wherever possible a satisfactory outcome for the complainant.

Requires improvement

Is the service well-led?

Our findings

Inconsistent quality assurance systems to monitor the running and overall quality of the service had failed to identify shortfalls and consequently improvements had not been made, as necessary. The registered manager was responsible for undertaking regular audits throughout the service. However the lack of social stimulation for people and the unsatisfactory levels of cleanliness and infection control, throughout the premises, demonstrated that this was an area that required improvement.

People and their relatives spoke positively about the manager and how the service was run. They confirmed they were asked for their views about the service and said they felt "well informed." Staff had confidence in the way the service was managed and described the registered manager as "approachable" and "very supportive." Relatives confirmed they were asked for their views about the service. They spoke positively about the level of communication and said they felt "well informed." One relative told us, "They keep us up to date with changes to care, but not changes affecting the service. We see these from notices on the notice board." We saw evidence on the notice board that 'Resident and Relatives' meetings had been held in the past. The most recent recorded meeting was on 29 July 2015. However the board also indicated that the last two scheduled meetings had been cancelled. This was confirmed by a relative who told us, "They used to have regular relatives' meetings here but, for some reason, there hasn't been one for a while." When we discussed this issue with the business manager, they acknowledge meetings had slipped during a recent unsettled period. However they said they recognised the importance of effective communication with people in the home and their relatives and assured us they would be reinstating such meetings in the near future.

Staff were aware of their roles and responsibilities to the people they supported. They spoke to us about the open culture within the service and said they would have no hesitation in reporting any concerns they had. They were also confident that they would be listened to, by the manager, and any issues acted upon, in line with the provider's policy. Staff also spoke to us about the communication which they described as "Generally pretty good." Although when we asked about the most recent staff meeting that was held, they couldn't remember. One member of staff told us, "I'm sure we've had one this year." When we looked at minutes of meetings, we saw that the last staff meeting was held on 27 January 2015. We observed a comprehensive handover between senior carers at the start of the afternoon shift. It comprised updates on each person in the home, as well as any visits or appointments by health professionals, including any recommendations or changes in medication.

We discussed the culture and ethos of the service with the business manager and staff They told us, "It's all about teamwork, valuing individuality, promoting independence and developing staff". A member of staff said, "It's been a bit unsettled and it has its ups and downs, but we're a good team and support each other." Another member of staff told us added, "I love working here and love the residents. That's why I'm still here after all these years." A colleague added "Everybody is so friendly, I really enjoy it here and I think most people are happy."

The registered manager had notified the Care Quality Commission of any significant events, as they are legally required to do. They promoted a good relationship with stakeholders. For example, the manager took part in reviews and best interest meetings with the local authority and health care professionals.

There were systems in place to record and monitor accidents and incidents. We reviewed these and found entries included details of the incident or accident, details of what happened and any injuries sustained. The manager told us they monitored and analysed incidents and accidents to look for any emerging trends or themes. Where actions arising had been identified, recording demonstrated where it was followed up and implemented. For example, following an accident we were able to see the actions that had been taken and how the on-going risk to this person was reduced.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered provider had not ensured that the care and treatment, including meaningful activities, for people using the service was appropriate to meet their needs and reflect their preferences. Regulation 9(1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use the service were not always protected from risk to their health and safety, as the registered provider did not ensure that appropriate standards of cleanliness, hygiene and infection control were maintained. Regulation 12 (2) (h).