R S Oakden

Penkett Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 16 March 2017 and was unannounced,

Penkett Lodge provides personal care and accommodation for up to 27 people. Nursing care is not provided. The home is a detached four storey building in Wallasey, Wirral. A small car park and garden are available within the grounds. There are twenty one single bedrooms and three shared bedrooms with communal bathrooms on each floor. Some of the rooms are en-suite. A passenger lift enables access to bedrooms located on upper floors and specialised bathing facilities are available. On the ground floor, there are two communal lounges and a dining room for people to use. At the time of our visit, there were 26 people who lived at the home.

The home had a 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 2008 and associated Regulations about how the service is run'. The registered manager had been employed at the home for over five years.

During this inspection, we found breaches of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to respecting people's right to choose and safe medication management. You can see what action we told the provider to take at the back of the full version of this report.

We looked at the care files belonging to four people. We saw that people's capacity was assessed where their ability to make informed decisions was in question. Where people were assessed as lacking capacity, a best interest decision process had been undertaken before any decisions were made on the person's behalf. It was clear from looking at people's records that the manager had considered the Mental Capacity Act 2005 (MCA) when assessing people's capacity but at times the way people's capacity was assessed did not comply in full with the MCA legislation. We spoke with the registered manager about this.

During the visit, we saw that one person's ability to decide for themselves where they wanted to spend their time was not always respected or followed. This meant that this person's liberty was restricted. There was a risk that this restriction was unlawful. We spoke with the registered manager about this. They told us that staff did not act on the person's wishes to go to their room as they were worried they may have a fall. They acknowledged that the person's right to choose where they spent their time should have been respected and facilitated by the staff team and the risks managed appropriately.

We observed a medication round. We saw that staff did not always observe people taking their medication before they signed the person's medication administration record. This meant that staff could not be certain that the person had actually taken it before they signed to say that they did. We found that some of the eye drop medication at the home was not stored safely and some of the medication had exceeded it

expiry date but was still in use. This placed people at risk of harm.

We saw two incidences staff supported people's moving and handling needs in an inappropriate way. On both occasions the staff members supported people's weight to transfer to or from a seat using an underarm lift. This type of lifts can cause physical injury to both the person requiring support and the staff member. We spoke with the manager about this.

People's care plans described their individual needs. People's wishes and preferences in the delivery of care were documented. There was clear guidance for staff to follow to ensure that people's needs were met and their risks managed. We saw that people received care from a range of health and social professionals. For example, doctors, dentists, district nurses, occupational therapy, community dieticians and chiropody services.

We found information in relation to people's health needs was brief. For example, there was limited information about the signs and symptoms to spot should a person's medical condition decline. The staff we spoke with however did have an understanding of these needs and how to manage them.

People we spoke with were very complimentary about the staff, the manager and the service they received. People told us that they were well looked after, treated kindly and that the home was a nice place to live. All of the people we spoke with felt that staff had the skills and abilities to meet their needs and said that the manager was approachable and easy to talk to.

Staff were recruited safely and had received the training and support they needed to do their job effectively. People's feedback on staffing levels was mixed. During our visit we saw that staff were busy supporting people with personal care with little time to sit and chat to people socially. A visible staff presence in communal areas was also sometimes not evident. We observed however that the support people received was unrushed and we did not see anyone waiting long periods of time for staff to support them. People looked happy and relaxed in the company of staff and it was clear that staff and the manager knew people well.

People had access to sufficient quantities of food and drink and suitable menu choices at each mealtime. The cook and staff had a good knowledge of people's dietary needs and preferences and people we spoke with told us the food was of a good quality.

During our visit, we observed that staff treated people kindly and supported them at their own pace. People looked smartly dressed and well cared for and actively participated in the activities on offer. This promoted people's emotional well-being.

People told us they felt safe at the home and they had no worries or concerns about their care. Staff we spoke with were knowledgeable about potential signs of abuse and how to protect people from harm. They spoke warmly about the people they cared for and from our discussions it was clear they knew about 'the person' as opposed to just the care that they had to give.

The home and its equipment were safe and regular audits were undertaken to monitor the quality and safety of the service. Some improvements to the overall management of the service were however needed to ensure that risks in the day to day practices of staff were picked up and addressed.

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 always safe.

People told us they felt safe and had no worries or concerns.

People's needs were risks assessed and managed and people received support from a range of healthcare professionals.

Staff were recruited safely but people's feedback on staffing levels was mixed. During our visit no-one waited long periods for support but staff had little time to chat to people socially.

The storage and administration of medication was not always safe.

Staff knew how to safeguard people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

There was evidence of good practice in relation to the MCA but the assessment of people's capacity did not comply in full with the legislation.

People's right to choose and consent to their care was not always respected appropriately.

People told us that the staff were good and they had the skills and abilities to meet their needs.

People were given enough to eat and drink and a choice of mealtime options to meet their needs and preferences.

Staff were trained and supported in their job effectively.

Is the service caring?

Good

The service was caring.

People we spoke with held staff in high regard. Staff were kind, caring and treated people with respect.

People were happy and relaxed in the company of staff. They looked smartly dressed and well cared for.

Discussions had taken place with people about their end of life wishes and staff at the home had recently achieved accreditation with the NHS Six Steps End of Life Programme.

Is the service responsive?

Good

The service was responsive.

People's needs were individually assessed, care planned and reviewed regularly.

People told us that their needs were met. They said if they became unwell staff rang the doctor to ensure they received the support they needed.

A range of social activities was provided by an activities co-ordinator.

People told us that they were happy to talk to the staff or the manager if they had any concerns or complaints.

Complaint records showed the manager responded appropriately to any complaints received.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems were in place to monitor the quality and safety of the service. Some of these were effective but others failed to identify issues with day to day staff practices that impacted on safe and effective care.

People's satisfaction with the service was sought through a satisfaction survey. The results showed that people were pleased with their care.

Penkett Lodge

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 16 March 2017. The first day of the inspection was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Prior to our visit we looked at any information we had received from the provider in relation to the home. We also contacted the local authority and a healthcare professional for their feedback on the service provided. We used this information to plan our inspection.

On the day of the inspection we spoke with eight people who lived at the home, a visitor, two care staff, the cook and the registered manager.

We looked at the communal areas that people shared in the home and visited a sample of individual bedrooms. We reviewed a range of records including four care records, medication records, staff records, policies and procedures and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

We spoke with eight people. All eight people told us they felt safe at the home. People's comments included "There's always somebody there if you want them"; "They look after us very well"; "The staff are very good, they are keen to help you" and "Everybody's very friendly".

We looked at the arrangements in place for safe management of medication. We saw that people's medication was mostly dispensed via monitored dosage blister packs. There were some 'as and when' required medications for example, painkillers that had been dispensed in individual boxes for when people needed them.

We checked a sample of people's medication administration charts (MAR). We found that stock levels balanced with what medicines had been administered. This indicated that people had received the medication they required. People we spoke with confirmed this.

We found that that some of the 'as and when' required medication and their instructions for use, had been handwritten on people's medication administration records (MARS). These handwritten entries were signed for by the member of staff who had written them but their accuracy had not been double checked by a second member of staff. This meant there was no robust system in place to check handwritten MARs were correct before use.

Some medications which required refrigeration were stored in a medication fridge, but others were not. We found that some medications with a shelf life of 28 days had not been dated when opened. This meant it was impossible for staff to know when the 28 day 'safe to use' period had expired.

For example, two people's eye drops which had a shelf life of 28 days had not been dated when opened. This meant staff could not be sure they were still safe to use. Another person's eye drops were dated but were still in use after the 28 day period had expired. This meant there was a risk that the eye drops were no longer effective or safe to use. Some of the eye drops found in medication trolley also required refrigeration to maintain their effectiveness and quality.

We observed two separate medication rounds. The medication rounds we observed were undertaken by two different staff at two different times of the day. We observed that both staff members failed to ensure that some people who were given their medication, had actually taken it, before they signed the person's medication administration record (MARs). Staff administering medications should always observe the person taking the medication before they sign people's MARs. This is because they cannot be sure the person has taken the medication if they don't observe consumption. In addition they are signing the person's MARs to confirm they have witnessed the person taking it.

These issues demonstrate that the way in which medications were ordered and accounted for at the home required improvement. This was a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we observed two incidences where inappropriate moving and handling techniques were used to support people with mobility issues. This placed people at risk of an accident or injury. We spoke to the manager about this at the end of the inspection. They told us they would address this with the staff team without delay.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the moving and handling support provided was not safe and did not mitigate the risk of potential harm.

We looked at the care files belonging to four people and saw that people's risks in the delivery of care were assessed. There were suitable risk management plans in place for staff to follow and daily care records showed people's risk management plans were followed. For example, risks in relation to nutrition, falls, challenging behaviour, moving and handling and the development of pressure sores were all assessed and managed. People's risk management plans were monitored regularly to ensure they were up to date.

We looked at the personnel files belonging to three members of staff and saw they were recruited safely. Pre-employment checks were undertaken which included the verification of the staff member's identity, previous employer references and a criminal record check. This meant that the manager had undertaken the necessary checks to ensure people employed were safe and suitable to work with vulnerable people, prior to employment.

We asked people who lived at the home whether they felt there were enough staff on duty to meet their needs. People's feedback was mixed. People's comments included "It depends how busy they are, there's times when they are very busy, they can't do miracles"; "They seem to have quite a bit of staff. I've never thought about it" and "There seems to be, you've got to be understanding when you pull your call bells. One person said "They could do with one or two (staff) more" and another said "They come pretty quickly they could do with more staff".

We saw that the majority of people sat in the communal lounge. Staff were not always a visible presence in this area and people told us that staff didn't have much time to sit and chat with them. One person told us "They'll talk if they are not too busy". Another said "They're all very friendly, laughing and joking with them. It's a nice environment". A third person said "Talk? Occasionally but not very often. I would like them to talk to me more. During our visit we did not hear people's call bells ringing frequently or for long periods of time to suggest that people's needs were not met by the number of staff on duty. We did see however, that staff were often too busy meeting people's practical needs to sit and chat to them socially.

Regular health and safety checks were carried out on the premises and the equipment in use at the home. The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected by external contractors who were competent to do so. On the day of our visit, the home was clean and well maintained. We saw that some areas of the home had been refurbished and this work was ongoing.

There were personal emergency evacuation plans in place to advise staff and emergency services how to evacuate people safely in the event of an emergency. Appropriate fire evacuation procedures were in place and a regular check of the home's fire system and emergency lighting was undertaken.

We reviewed a sample of people's accident and incident records. Accident and incident records were completed appropriately with body maps in place to record any injuries that people had sustained. Records showed that appropriate action had been taken when an accident or incident had occurred.

We saw that the provider had a policy and procedure in place for identifying and reporting potential safeguarding incidents. Staff were trained in how to safeguard vulnerable adults. They were able to tell us about potential signs of abuse and the action they would take to protect people from harm.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care 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.

We saw that people's capacity was assessed when their decision making ability was in question. It was obvious the manager had considered the MCA when assessing people's capacity to make decisions. For instance people's capacity had been assessed on three different occasions to determine whether their capacity fluctuated, their capacity to make decisions was reviewed regularly and consideration was given to what decision was in the person's best interests. We found however people's capacity assessments did not clearly identify the specific decision the person's capacity was being assessed for. As a result of this, the provider's assessment process did not comply in full with the MCA legislation. We spoke with the manager about this.

During our visit, we saw that one person's right to choose how they lived their life at the home was not respected. During the afternoon, the person was sat in the communal lounge. We heard them continually ask staff to take them to their room so that they could go to bed. Although staff acknowledged the person's repeated requests, they simply replied "It's too early" and "Not now later". We heard the person ask "Why can't I go to my bedroom" and "I want to go to bed. I want to go to sleep". We were concerned that this person's liberty was being restricted unlawfully. We spoke with the manager about this immediately. They explained that staff were worried about the person having a fall if they were alone in their bedroom. They acknowledged that staff should have respected the person's wishes to go to their room and managed the risk of a potential fall accordingly.

We asked other people who lived at the home whether they could get up and go to bed when they wanted and their responses were mixed. Some people said they couldn't decide what time they got up whereas others said they could please themselves. Some people said ""They come and get me up, sometimes you wait, sometimes you don't"; "They come and get you up at different times, they wouldn't let me stay in bed if I wanted to" and "Not really, they always seem to have duties to do. I've been up at few hours now".

Other people told us "They don't get me up. I get up when I want, especially at my age"; "They leave me and give me a bed bath at 10:00 or whenever I want and "They come when you want". This suggested that sometimes people routines were determined by what tasks the staff needed to complete each day. This

meant there was a risk that people's right to choose how they lived their life was not always respected.

Everyone we spoke with spoke highly of the manager and felt staff were trained to meet their needs. People comments included "I think they're very good, they know what they are doing"; "They're very good bathing me and regular. You get washed and changed when necessary"; Staff are "Very good, they're marvellous" and "They're good, if you need anything, they get it for you".

Staff we spoke with had good knowledge of people's needs and how to care for them safely. We saw that they received training in a range of topics such as safeguarding, medication administration, moving and handling, health and safety, fire safety, food hygiene, first aid and infection control. Some of the training was due to refreshed at the time of our inspection.

Records showed that staff received regular supervision by the manager and an annual appraisal of their skills and abilities. Newly employed staff had received an induction into their job role and ongoing supervision during their probationary period of employment. This was good practice as it ensured that the staff member was competent to work unsupervised once the probationary period was completed.

People told us the food was good and they had plenty of choice. One person said "I like it all, if I didn't want something, they'd go and find me something else instead". Another person told us "The food is smashing, we get a good variety. We get a lot of veg but not many chips". A third person told us "They (staff) come with a list and ask you what you want for dinner and tea you have choice of two items for each meal".

When asked if they got enough to eat and drink, everyone we spoke with said they did. One person told us "I enjoy the food I eat, I've got a small appetite, they tell me, if you are hungry buzz". Another person said "The food's good and there's always more if you want it".

On the day of our inspection, we saw that the cook had prepared about five different variations of the lunchtime meal in accordance with people's wishes. There were also four different types of drinks to choose from. We saw that people's portion sizes varied in accordance with the person's appetite and preferences which showed that staff knew people's needs well. Bread and butter was served with each person's meal but there were no side plates in use. The bread and butter was either put on the side of the person's main plate or on their place mat which was not very dignified. We also saw two carers picked up people's cups to pour tea in, by putting their fingers inside of the cup instead of picking it up by the handle. This was not very hygienic.

Staff served people's meals pleasantly and promptly but we found that the atmosphere at lunch was rather sterile. There was no music or conversation and the décor of the dining room was bland. We found that people's lunchtime meal was functional i.e. it was solely for the purpose of eating rather than providing an opportunity for people to socially interact and enjoy their meal with each other. A positive atmosphere during mealtimes has been shown to stimulate people's appetites and make mealtimes an enjoyable experience.

After lunch, we spoke with the cook on duty and asked them about people's special dietary requirements. We found they had a good knowledge of people's needs and preferences. They were able to tell us how they ensured people's needs and preferences were met when meals were prepared.

Records showed that people's weight was monitored and responded to appropriately when their needs changed. Information in people's care files with regards to their health or medical needs. was brief. For instance there was no information on how to recognise the signs and symptoms to spot should people's

health decline. We found however that the staff we spoke with were able to describe these needs and the action to be taken if the person became unwell. This assured us that any signs of ill-health would be picked up and addressed promptly.

We saw that the manager had ensured people had access to appropriate support services where specific risks in relation to their health and well-being were identified. For example, the falls prevention team, district nurses, occupational therapy and access to specialist healthcare for people who lived with health or medical conditions that impacted on their physical wellbeing. This demonstrated a proactive and well organised approach to ensuring people remained safe and well for, as long as possible.

Good

Is the service caring?

Our findings

Everyone we spoke with told us staff were kind, caring and respectful. People's comments included staff were "Lovely "; They're all very nice, they're kind"; I think they're very nice, kind and considerate"; "Smashing they're like family now, better than family" and "The staff are very kind, I haven't come across one person who didn't want to help you, they are so nice with you".

We observed throughout the day that staff spoke with people who lived at the home in a polite and friendly way. They supported people patiently, promoted people's independence and were respectful of the need for people to take their time to achieve things for themselves. We saw that people who required mobility equipment to maintain their independence had the equipment in place to enable them to do so.

People's bedrooms were clean and tidy and were personalised with the person's own things and choices. It was clear that the manager had ensured people's bedrooms were a pleasant and familiar environment for people to live in. People looked comfortable and well dressed and it was obvious staff took the time to assist people to look their best. The atmosphere at the home was homely and people looked comfortable and relaxed in the company of staff. Interactions between people who lived at the home and staff were positive and pleasant.

People told us that staff did not routinely have the time to sit and chat with them, but if they were worried about something, staff would make the time. This indicated that staff cared about people's emotional well-being but that there was little time in their working day for them to meaningfully engage with people on regular basis.

Staff we spoke with spoke warmly about the people they cared for. One staff member said "I love the residents". Both staff members demonstrated a good understanding of people's needs and care. People we spoke said that staff knew them well.

We saw that people's wishes in relation to their end of life care had discussed with them and documented for staff to follow. We saw that some people had do not resuscitate decisions in place to advise staff of their advance wishes in the event of ill-health. Staff at the home had recently completed and been accredited by the NHS Six Step End of Life Training Programme. This meant they had demonstrated they had the skills and knowledge to care for people appropriately at the end of their life.

We looked people's daily written records and saw that people had received care and support in relation to their personal care and that staff monitored their general well-being.

Records relating to people's needs and care were stored securely in a locked room which ensured people's right to privacy and confidentiality were protected.

Good

Is the service responsive?

Our findings

People we spoke with said that the staff looked after them well. One person said "They couldn't be better, kind and considerate, some (staff) have been here for years"; A second person said "If I need anything, they'll hurry up and get it for you". A third person told us "I get good care".

We saw from people's records that the service was responsive when people's needs changed or they became unwell. Everyone we spoke with said staff ensured they got to see a doctor if they became poorly. People's comments included "Yes, they know when to send for one"; "They would do if I needed one" and "Yes and I've had an eyesight test whilst I've been here".

We found people's care plans to be person centred with information about the person, their likes and dislikes and wishes in relation to their care. People's care files contained information about their life prior to coming to live at the home. This information captured the person's memories, family history and gave staff details of the things that were important to the person in the day to day life. This helped staff gain an understanding of the person they were supporting and helped build positive relationships.

A poster in the entrance area of the home advertised the range of social activities available at the home. A range of activities were offered such as skittles, play your cards right, tin can alley, chair based exercises, bingo and pitch and putt. People we spoke with told us activities were regularly available but some people said they didn't get to go out on organised trips very often.

People's comments included "In the afternoon, we have games and such, I enjoy the games"; I do crosswords and get the Echo every night. I've got my telly and I play bingo"; "I read the paper and watch the telly. They have a lady who comes in five afternoons and we play bingo and other games. We don't go out on trips"; "Trips? No I haven't seen fresh air for ages. I would like to go out" and "I listen to the television and join in the activities occasionally, no trips".

During our visit, we observed the activities co-ordinator arranging activities in the communal lounge. It was clear the activities co-ordinator knew people well. They chatted to them socially and encouraged everyone to join in. We saw that most people joined in with the ball games and magnetic darts. The atmosphere was warm, jovial and inclusive. This promoted people's emotional well-being.

We looked at the provider's complaints procedure. We saw that it explained how people could make a complaint but failed to provide people with the name and contact details of who to direct their complaint to. For example, no contact details were provided for the provider, the Local Authority, Care Quality Commission or the Local Government Ombudsman. This meant people may not know who to direct to their complaint to. The provider was advised of the missing contact information at the last inspection but the details had still not been added.

People we spoke with had no worries or concerns about their care. They told us that they would speak to one of the staff or, the manager if they had any concerns. One person told us "There's a couple of motherly

types (staff), I'd talk to them". Another told us "No worries, I'd talk to the manager" and a third person said "I'm happy with it (their care). Otherwise I'd talk to the boss".

We reviewed the provider's complaints records. Complaints about the service in the last 12 months were minimal. We reviewed one complaint. We saw that the manager had thoroughly investigated the complaint. They had responded to it appropriately and within the timescales set by the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

We asked people who lived at the home and the staff employed if they thought the home was well managed. Everyone we spoke with said it was.

One person we spoke with said "It's somewhere to be where everybody looks after you. If you've got to be somewhere, I'm happy it's here". Another person said "A lot of things are good, the staff are all really good. It's a nice place to come to. I feel I'm welcome here".

People we spoke with spoke highly of both the staff team and the manager. People said that the manager was approachable and were complimentary about the support they provided. One person said "Yes, they (the manager) are great" and another said "They are easy to talk to".

We asked people what they liked best about the home. People's comments included "The carers"; "The people, there is always someone around. There's always someone to make me laugh and I can go out in the garden in the summer" and "The way the residents are treated, like they should be, with dignity and respect. The staff are very caring". It was clear from people's comments, that they liked life at the home and they liked the staff. One person said "I wouldn't like to leave I'd be upset if I had to leave". People's feedback showed that the manager led the delivery of kind and compassionate care well.

A number of regular audits were in place to monitor the quality and safety of the service. For example, care plan audits, accident and incident audits, falls audits, equipment audits and maintenance audits. These audits were effective in identifying and addressing where improvements were required in these areas in order to mitigate potential risks. We found however that the auditing and governance systems in place failed to identify other areas were the service required improvement.

For example, the audit systems in place failed to identify that the management of medication required improvement. This was because the provider's medication audits and staff competency checks failed to pick up that some staff were not administering medications in a safe way. The medication audits in place also failed to pick up that some people's eye drop medication was not stored appropriately or used by its expiry date.

The systems in place to supervise and monitor the day to day practice of staff failed to identify and address the day to day staff practices that impacted on people's care. For example, the provider's audit systems failed to identify that sometimes the day to day practices of staff disregarded people's legal right to consent to their care or that some of the moving and handling techniques in use were unsafe and placed people at risk of avoidable harm.

The failure to identify and mitigate these risks in order to ensure safe and effective care was provided at all times was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager about how people's feedback and involvement in the running of the service was facilitated. They told us that resident meetings used to take place regularly but a meeting hadn't taken place for a while. They told us that they were in process of reviewing of how they engaged with people and said that resident meetings were due to re-commence.

We saw however that a satisfaction survey was completed by people who lived at the home in May 2016. The results of the survey were displayed in the entrance area of the home for everyone to see. 15 people had responded to the survey and the results were positive.

For example, when people were asked about the quality of the care they received, the majority thought it was very good and two people rated it excellent. Three people rated the choice of food and activities on offer as excellent and everyone else gave them a rating of good or very good. This demonstrated that the provider had systems in place to gain an informed view of people's opinions of 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	Regulation 11 HSCA RA Regulations 2014 Need for consent Day to day care practices did not always enable people's consent and freedom of choice to be respected. Regulation 11(1) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The moving and handling techniques used by staff in support of people's mobility was not always safe and did not always mitigate risks to their health, safety and welfare. Regulation 12 (1)(2)(b). Medicines were not always managed or administered in safe way. Regulation 12(2)(g) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the provider's quality monitoring systems were ineffective in identifying and addressing inappropriate care and unsafe medication practices. This placed people at

risk of avoidable harm.

Regulation 17 (1)(2)(a)and (b).