Burlington Lovel Ltd

Alderson House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 May 2018 and was unannounced. This was the first inspection since the service was registered with the Care Quality Commission (CQC) on 5 July 2017 and therefore, the first time the service has been rated Requires Improvement.

Alderson House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection. Alderson House supports up to 32 people, some of whom may be living with dementia, have a physical disability or a sensory impairment. At the time of the inspection, there were 20 people who used the service.

The service had a registered manager. A registered manager is a person who has registered with the 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.

A small number of people had not received their medicines as prescribed. This was due to errors in staff calculating when specific pain relief patches were due and on one occasion when staff were unable to locate a medicine. There were some minor recording issues and clearer guidance was needed for staff when people were prescribed medicines on a 'when required' basis.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

The provider had a quality monitoring system that ensured areas of the service and care provision were audited so improvements could be made and lessons learned. A new electronic recording system had just been introduced, which staff were not completely familiar with. This had meant some records such as food intake monitoring could be improved. Staff described the culture of the organisation as open and management as supportive and approachable.

Staff had received training and had procedures to guide them in safeguarding people from the risk of harm and abuse. In discussions, staff were clear about how they would escalate concerns and which agencies they would contact for advice.

Staff had completed assessments with people to identify risk areas and the steps required to minimise risk. Some risk areas had been overlooked and this was mentioned to the registered manager to address.

People's health and nutritional needs were met. Records showed people had access to a range of community healthcare professionals for advice and treatment. These included dieticians when people lost

weight and required additional support. The menus provided varied meals with choices and alternatives. People told us they liked the meals provided to them.

The staff supported people to make their own decisions and choices when they were able. When people were assessed as lacking capacity, staff consulted with relevant people when decisions were made on their behalf. The provider worked within mental capacity legislation to ensure deprivation of liberty applications were made.

People told us the staff had a kind and caring approach, and they respected their privacy and dignity. Staff asked people's consent prior to delivering care. People could remain at Alderson House for end of life care if they chose this option.

There were activities for people to participate in but these could be improved. As they were currently provided by care staff, the provision could be disjointed when they were called away for personal care tasks. Recruitment was underway for an activity coordinator, which will resolve the issue.

Staff were recruited safely and checks were carried out before they started work in the service. There were sufficient care staff on duty to meet people's needs. There were ancillary staff, which enabled care staff to concentrate on caring for people.

Staff received training, supervision and appraisal to ensure they were skilled and confident in meeting people's needs.

The provider had a complaints procedure and people told us they felt able to raise concerns and these would be addressed by management.

The environment was clean, tidy and safe. Staff had access to personal, protective equipment which helped them to prevent and control the spread of infection.

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.

Some people had not received their medicines as prescribed. This was due to errors in calculating when pain relief patches were required and with one person when staff were unable to locate a medicine.

Risk assessments were completed to guide staff in how best to support people safely. Some adjustments were required to ensure they were up to date.

Staff knew how to safeguard people from the risk of abuse and how to pass on concerns to relevant agencies.

There was a good recruitment system and sufficient staff deployed to meet people's needs.

The service was clean and tidy.

Is the service effective?

Good

The service was effective.

Staff had completed a range of training which enabled them to meet people's assessed needs.

People were supported to eat a healthy diet of their choosing.

People's health needs were met and relevant health care professionals were contacted in a timely way.

People's consent was gained before care and support was provided. The provider adhered to the principles of the Mental Capacity Act 2005 when establishing capacity and decision-making.

Is the service caring?

Good

The service was caring.

There were positive comments from people who used the service

and relatives about the kind and caring approach of staff.

Staff treated people with respect and supported them to maintain their privacy, dignity and independence.

People's personal information was held securely and confidentiality maintained.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs and care plans were produced to guide staff in how to support them in an individual and responsive way. People had provided information to contribute to the development of their care plans.

There were activities provided although these could be interrupted when care staff were called away. Recruitment was underway for a designated activity coordinator which would resolve this issue.

The provider had a complaints procedure on display and people felt able to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some improvements were needed with aspects of recording to ensure accurate and up-to-date information was readily available.

There was a quality assurance system which consisted of audits, checks and seeking people's views. Improvement was needed to ensure records were audited more robustly.

The culture of the organisation was open and responsive to improvements. Staff reported approachable and supportive management, senior managers and providers.

Alderson House

Detailed findings

Background to this inspection

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

This inspection took place on 1 May 2018 and was unannounced. The inspection team consisted of two adult social care inspectors.

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. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Before to the inspection, we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. 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. We spoke with four people who used the service and two people who were visiting their relatives. We spoke with the registered manager, the deputy manager and two care workers, one of which was a senior. We also spoke with a cook, a domestic worker and a member of staff who had dual roles of administrator and kitchen assistant. We received information from four health and social care professionals.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for 17 people and monitoring charts for food, fluid intake, weights and pressure relief.

We looked at a selection of documentation relating to the management and running of the service. These

included 3 staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the service and there was sufficient staff to meet their needs. Comments included, "Yes, I feel safe; I love it here", "I feel very safe here; there is always plenty of staff on duty", "Yes [sufficient staff], sometimes you have to wait at night but that can be because of an emergency" and "Yes, definitely [feel safe]. The fire alarm went off last night and the door closed. I know you stay where you are but I felt safe." This had been a false alarm. Relatives said there was enough staff on duty.

Health and social care professionals also had positive comments to make. They said, "Yes, the service appears safe for the people that live there. There does seem to be sufficient staffing levels when we have visited."

Medicines were stored appropriately. Most people received their medicines as prescribed. However, records showed there were occasions when two people had not received pain relief medicine, in the form of a controlled drug skin application patch, as prescribed. On three occasions, one person received the skin patch a day late and another person was a day early for their weekly patch. There was also an occasion when staff recorded on a person's medication administration record (MAR) that they were unable to locate a specific pain relief medicine for two days; the person was prescribed this four times a day. One person was prescribed a pain relief gel three times a day but staff had been applying this four times a day. Clear directions were needed to guide staff when administering medicines prescribed 'when required' for pain relief and conditions such as shortness of breath and constipation. There were also minor recording issues which were discussed with the registered manager and deputy manager during the inspection to address.

Staff completed risk assessments for people. These included areas such as smoking, nutrition, choking, skin integrity, falls, moving and handling and specific health care needs. One person had a risk assessment and care plan for distressed or anxious behaviours that could be challenging to others. This was comprehensive and provided guidance for staff in how to support the person in a safe way. However, a small number of risk assessments had not been updated to reflect changes in people's needs or had not been fully completed. For example, one person took a specific blood thinning medicine and had a history of falls. The falls risk assessment did not include the action to take following a fall in light of their medication. This was discussed with the registered manager who told us they would address it. On one occasion, we saw a person in bed had only one bed rail in position; their risk assessment stated they were to have bedrails up for their own safety when in bed. This was addressed straight away by the registered manager.

These issues were a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us they received their medicines on time and they were not left in pain. Comments included, "My medication is stored safely" and "The staff give me my medicines but I don't know what I take." Visitors said their relative's medicines were managed well. Staff had received training in medicines management and competency checks. The registered manager confirmed these were to be reviewed in light of the inspection findings.

The provider had policies and procedures to guide staff on how to safeguard people from the risk of abuse or harm. Staff had received training and in discussions were able to describe the different types of abuse and the procedure to follow if they had concerns. The registered manager had contacted the local safeguarding team for advice when required. The administrator described the system in place to protect people finances. This included ensuring receipts were obtained for monies deposited for safekeeping or when people requested their money to make purchases.

There were sufficient staff on duty in the service at all times. There were four care staff, including a senior on duty during the day and three staff at night; the staff worked 12 hour shifts which assisted continuity. The registered manager worked Monday to Friday. The deputy manager worked some days as a senior and had one day supernumerary to enable them to complete administration tasks such as staff supervision. There was a range of ancillary staff such as catering, domestic, laundry, administration and maintenance, which enabled care staff to focus on their caring role. The deputy manager had been completing three days a week as a cook recently as one of the cooks had left; a new cook had just been appointed.

The provider had a safe staff recruitment system. Potential staff completed an application form so gaps in employment history could be identified, references were obtained and they attended for interview. When applicable, documents were copied and held on file regarding the person's right to remain and work in the UK. A Disclosure and Barring Service (DBS) check was carried out to highlight any criminal convictions and barring from work in care settings. These measures assisted the provider in making safer recruitment decisions.

The environment was clean and safe. Equipment used in the service was checked and maintained; there was a system for identifying repairs so these could be passed to maintenance personnel for completion and sign off when actioned. People who used the service had personal, emergency, evacuation plans which detailed the level of support they required should evacuation of the building be required. Staff had access to personal, protective equipment such as gloves, aprons and hand sanitiser to assist them in preventing and controlling the spread of infection.

The provider had a business continuity plan, which provided staff with guidance on what to do in case of flooding, outbreak of infections, fire or utility failure.

Good

Is the service effective?

Our findings

People said they were encouraged to do what they could for themselves whilst being supported by the staff, which helped to maintain their independence. One person told us, "I love it, staff are fantastic: they have the patience of saints." Another person said, "They [the staff] let me do things for myself."

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.

The Care Quality Commission (CQC) is required by law to monitor the use of the Deprivation of Liberty Safeguards [DoLS]. This is legislation that protects people who are not able to consent to care and support and ensures that they are not unlawfully restricted of their freedom or liberty. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities and had made 12 DoLS applications, which were all awaiting authorisation by the local authority. One person had lasting power of attorney (LPA) documentation in their care file. It was important staff had information about LPA and the extent of powers so they knew who to consult with regarding decisions made in their best interest.

Where people had been assessed as lacking capacity to consent to some aspects of care such as the use of bedrails or sensor mats, recording of decisions was inconsistent. Consultation with relevant others was sometimes verbal rather than recorded in best interest decision documentation. This was discussed with the registered manager who told us they would address in future documentation.

People who used the service told us staff gained their consent before carrying out any care tasks and they were able to make their own decisions. They said, "I can decide if I have my meals in the lounge or my room" and "I have started to be more involved and help the staff." In discussions, staff were clear about the need to gain consent before care tasks were carried out; this was observed during the inspection. We observed staff delivering care and support to people in the communal areas of the service. They spoke with people, gave them choices and supported them to make their own decisions, for example what they would like to eat and where they wished to sit and spend their time.

People's health care needs were met. A range of healthcare professionals were involved in the care and treatment of the people who used the service. We saw that advice and guidance had been provided by GPs, community psychiatric nurses, specialist nurses, dieticians, opticians and chiropodists. This helped to ensure people continually received the most effective care to meet their needs. Health care professionals confirmed they were contacted in a timely way. Comments from them included, "We are kept informed of any changes" and "I have always found staff to be attentive and supportive. My client has complex needs, which they have managed brilliantly; their family feel the same." A relative told us, "Mum has had optician

visits and dental care."

People's nutritional needs were met. Each person had a risk assessment completed and were weighed in line with it. There were care plans which included food preferences and dislikes. People were supported to eat a balanced and nutritious diet. The cook told us, "People choose their preferred option from a daily menu that is part of a four-week cycle and there are always two main course options and one dessert with alternatives if required." People could choose where they wanted to eat, either in their rooms or in the dining areas. Staff asked people what they wanted to eat and pictorial menus were in place to help people to choose what they wanted. We observed people eating lunch at shared tables, which were set to look appealing and welcoming. The food served looked appetising and nutritious. Comments from people who used the service included, "The food is brilliant; I can't fault it" and "The food is excellent; great chefs who are always kind and good to everyone."

All staff completed a three-day induction which included training considered essential by the provider. This included moving and handling, fire safety, dementia awareness, safeguarding, health and safety, infection control and person-centred care. Staff also completed three days shadowing more experienced staff as part of their induction. Other training included first aid, end of life care, documentation, food hygiene and managing behaviours which could be challenging to others. Staff who administered medicines had completed training. The training records identified when updates were required.

Appropriate staff were enrolled to complete the care certificate. The care certificate is a nationally recognised qualification for the care industry. This helped to ensure people were supported by staff who had the skills and abilities to meet their assessed needs effectively. The registered manager told us they were looking for specific specialist training in conditions that affected some of the people who used the service; these included Multiple Sclerosis and Parkinson's Disease.

We saw regular supervisions and yearly appraisals were taking place, however, one member of staff had not had any supervision since they started employment in December 2017. This was mentioned to the registered manager to address. A member of staff said, "There is plenty of scope for development and promotion within the company and I am a prime example of that" and "Management support is fantastic".

Good

Is the service caring?

Our findings

There were positive comments about the staff team approach and their caring attitude. People who used the service said, "The staff are very friendly; they are like an extended family", "Yes, they definitely do [promote privacy and dignity]; when I get up first thing, the doors are closed", "My best mates are the nurses [care staff]" and "Yes, they are good [when providing personal care]."

Relatives said, "I know all the staff's first names. They cope very well with [Name of person] and I can't speak too highly. They are all first class – lovely and caring" and "Staff do appear to be there for us."

Health and social care professionals said, "Privacy and dignity were upheld during our visits." One health professional told us staff had not offered them the choice of talking to their patient in their own bedroom but directed them to the lounge instead. Another professional described how the registered manager had supported their client in a very caring and empathetic way which alleviated distress and anxiety.

In discussions with staff, they described how they promoted privacy and dignity. Comments included, "If people need personal care, this is completed in their bedroom and the door and curtains shut", "I would expect staff to have a quiet word with people [if they need personal care] and not shout across the lounge", "We ask people what they would like, support them to a private room for personal care and close curtains and doors" and "We keep people covered up [during personal care], explain things and be respectful." The deputy manager told us they were the dementia and dignity champion. They said this role was to observe staff practice and provide guidance when required.

Each person had their own en-suite which afforded them privacy. There were privacy locks to bedroom and bathroom doors.

There were lots of 'thank you' cards on display from people who had used the service temporarily and from relatives. These referred to the kindness of staff.

We observed staff spoke with people in a kind and patient way. They made sure they were on the right level to make eye contact them and had a friendly approach. They provided explanations to people before carrying out care tasks such as support with transferring from wheelchairs to comfy chairs or walking with a frame. During administration of medicines, the staff chatted to people, explained what they were for and provided a drink of water. During support at mealtimes, staff were attentive and asked if people had received enough to eat.

People were provided with information displayed on notice boards around the service. The daily menu was on display in the dining room written on a chalk board and there were pictorial menus to assist people to make choices. The menu was also on display on a notice board in reception along with minutes of the residents meetings and the complaints procedure. There was some signage around the service but this could have been better and been in symbol/pictorial format; this would assist people living with dementia to find their way around their home. Bedroom doors had people's name or a number on and we discussed

with the registered manager the need for pictures or other reminders for people living with dementia.

The provider's statement of purpose referred to the importance of respecting people's civil rights and promoting their diversity. We saw staff supported people in an individual way, for example with their religious and cultural needs. One person received visits from a nun to support their spiritual needs. Staff were aware of which people did not celebrate usual traditions and respected these.

Staff were aware of the need for confidentiality. Telephone calls or discussions with health professionals or relatives were made in a private office. Personal information was stored securely and computers were password protected. The provider was registered with the Information Commissioners Office which was required when records were held electronically.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. Comments included, "The staff are very well-trained and cater for each person individually. I have made a lot of friends here" and "Yes, I have seen my care plan." Relatives said, "[Name of person] was not well a couple of weeks ago and the senior reacted really well to the problems, checked them out at hospital and rang me at home; it was very good" and "Mum plays bingo and enjoys watching films. Mum is able to be taken out in her wheelchair and enjoys the fresh air."

A health and social care professional stated, "Management and staff have been very flexible and adaptive to meet my client's psychological needs" and "I have always found them to be responsive and proactive in contacting other professionals." They went on to explain the registered manager had put daily measures in place to reassure the person and to make sure they felt settled. These included ensuring time was available to speak with the person and supporting them to write notes. They said, "This has had a huge impact on my client's wellbeing, as it has meant that they have been able to feel settled, more confident and comfortable, and have begun to join in activities. I feel [Name of registered manager] and other staff have gone above and beyond to accommodate them."

People had assessments of their needs and risk assessments completed. The registered manager also ensured copies of the assessment completed by local authority staff, 'My Life, My Way' was obtained prior to admission. People and their relatives had contributed to the information in care files. For example, each person had a 'map of life' which detailed important things in their lives, relatives and friends, previous work history and leisure activities they enjoyed. The information helped staff to see people as individuals with rich social histories rather than just recipients of care. Most people also had a list of preferences, likes and dislikes for food and fluids, which was shared with catering staff.

The information in assessments was used to formulate care plans. Some care plans were very detailed, for example, one described the step by step actions staff were to take to ensure a person was safe when they went out unassisted. Another described how the person used non-verbal means to communicate when they required the toilet. We saw other care plans could have provided more person-centred information although in discussions with staff it was clear they knew people and their needs very well. A member of staff said, "We base care on service user's needs; it's very person-centred."

Each person had a 'patient passport' which was provided to ambulance crews when they needed to take people to hospital for treatment. The 'patient passports' described people's current needs and the level of care they required; the information provided guidance to medical and nursing staff involved in people's care when they moved between services.

People were able to personalise their bedrooms with small items of furniture, pictures and ornaments.

People were able to remain at Alderson House for end of life care if this was their choice. A health professional stated, "We have looked after a palliative patient recently and worked with the staff well. They

have been receptive to our suggestions and feedback given."

There was no activity coordinator and the registered manager told us recruitment was underway. The activities were provided by care staff and subject to interruption when they were needed to attend to people's needs. There was an electronic record made when people participated in activities. We looked at the activity records for four people. These showed the activities provided included bingo, games such as dominoes, watching television and films, reminiscence sessions, hand massage, sing-a-longs and listening to music. One person had a doll and a 'twiddle mitten' with items sewn on it; they used this to relieve anxiety and we saw this brought them comfort. One person had been out to the cinema and the records showed lots of visitors came to see people. The recruitment of a designated activity coordinator will resolve the issue of interruption during the provision of activities. Some people told us they preferred to stay in their own bedroom and this was respected by staff. One person had purchased Sky television and this provided them with entertainment.

A health and social care professional stated, "I have always felt that they are open to suggestion if things haven't been going right. For example, when my client was feeling bored, they made an active effort to find activities that they could engage in, which they enjoyed. They allowed her to feel independent."

The provider had a complaints policy and procedure which was included in the service user guide and given to people when they were admitted; it was also on display in the service and included acknowledgement and response times. The registered manager maintained a log of complaints which showed how these were addressed. There were forms for people to complete if they wanted to formalise a complaint. We saw the minutes of residents/relatives meetings at which people were reminded that if they had any concerns these should be raised so they could be addressed. When we asked people if they were happy to make complaints, comments were positive and they felt able to do this. People who used the service said, "Yes, I would tell the lady at the desk" and "Oh yes, I would tell someone." Relatives said, "I raised a concern and got a good response", "They listen to any problems that do occur" and "We have meetings and problems get sorted."

Requires Improvement

Is the service well-led?

Our findings

People who used the service and their relatives knew the name of the registered manager and deputy manager, which showed us they made themselves available to people. There were positive comments from people about the management of the service. Comments included, "I have met [Name of registered manager] and they are lovely", "The deputy manager never fails to speak to everyone and talks to everyone just the same", "I get invited to resident's meetings but I would rather watch my TV" and "I think she [registered manager] is very good."

Relatives said, "It is now a massive improvement since the new manager came" and "They make sure the cleanliness of the home is very good."

Comments from health and social care professionals included, "A new manager had just started and they seem really on the ball and motivated to get things in place", "The manager meets and greets any visitors and appears well-informed about the residents. The staff appeared to be well-led" and "I have found the management at Alderson House to be professional and well-led. They have a proactive approach to ensure good partnership working with other professionals in their residents' lives."

There was an annual quality assurance system which consisted of audits, checks, surveys, meetings and visits by senior management. The registered manager completed a 'monthly return', which included information about people who used the service. This highlighted any pressure ulcers, gain or loss of weight, health professional involvement, acquired infections and treatment, hospital admissions, deaths, deprivation of liberty applications and bedrail use. There was also other information reported on, such as staff training, staff disciplinary, accidents and incidents, complaints and compliments. The monthly return ensured senior managers had oversight of the service and could contact the manager to check progress on issues or follow them up during their visits to the service. However, there were some areas of management oversight that required improvement.

We discussed the medicines errors regarding pain relief patch applications and the registered manager told us they had been made aware of this following a discussion with a relative in March 2018. They told us they had spoken to staff but had not recorded any discussions in team meetings or staff supervisions. There was no section to document medicines errors and action taken on the manager's month end report; this was discussed with the registered manager as a useful addition to the month end report.

Care files were audited and we could see some improvements had been made to care plans as a result. However, we saw evaluations of care delivered were not always carried forward to the care plan itself. This meant staff would have to read through various pages of evaluations to find the most up to date information. There were other records that required closer monitoring to ensure they were accurate and up to date. For example, some risk assessments and food monitoring charts. The latter did not identify the amount of food people consumed. The recording was completed electronically and was a new system. The records we looked at for a person at risk, who was also taking food supplements, identified they had been given breakfast, lunch and evening meals with snacks in between. However, there was no record of how

much the person had eaten. The registered manager told us staff were not yet fully up to speed with the new system and it was possible to include the amount of food people were given and what they had actually consumed. They told us they would address care plan evaluations and food monitoring records with staff and arrange additional training.

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

The electronic system was linked to hand-held devices and provided staff with prompts for tasks, for example reposition checks for pressure relief. This ensured that no important task was overlooked.

The regional manager completed visits to the service and provided the registered manager with a report of their findings and an action plan. We saw three reports of such visits from January 2018 by the previous regional manager and the latest report in April 2018 by a new regional manager. There were no reports in February and March 2018 due to a change of regional manager. The April 2018 report indicated checks were made of specific care plans records, for example, to ensure health actions such as referral to dieticians and the falls team had been completed; these had been completed in a timely way.

We saw the outcome report of a visit by a Quality Manager in January 2018 left actions for staff to complete. Following the visit, the issues were discussed in team meetings so staff were aware of them and why they had been raised. For example, the Quality Manager had identified disposable gloves were accessible to people living with dementia. Staff were made aware of the risks of ingestion and we saw during the inspection, the gloves were only accessible to staff. This showed us the staff team were open to learning and took note when improvements were required.

Residents/relatives meetings and staff meetings took place; records showed people were able to make suggestions about the way the service was managed and they were provided with information.

Staff told us they worked well as team, enjoyed coming to work, communication was good and the registered manager was supportive and approachable. They also said they had met the providers and senior managers when they visited the service. Comments included, "Everyone is aware of their roles and all get on; there is no, "It's not my job" and domestic and laundry staff are brilliant", "It's a friendly place; I like working here", "They [registered manager] are lovely and their door is always open" and "The manager is very approachable."

The culture of the organisation was focussed on people who used the service, open to suggestions, willing to learn from mistakes and supportive to staff. There was also a focus on quality monitoring with tiers of management to visit the service, complete audits and check improvements have been made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured all medicines were administered accurately and in accordance with the prescriber's instructions. Not everyone had all risks identified and managed to ensure they remained safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons implemented a quality monitoring system, however, this had shortfalls in ensuring all risk was identified and recorded, medicines were administered as prescribed and food monitoring charts were accurate.