Anchor Hanover Group

Trinity Fold

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 November 2018 and was unannounced. At our last inspection on 24 May 2016 we rated the service as Good. This inspection was to review the ratings.

Trinity Fold is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides nursing and personal care for up to 50 older people, some of whom may be living with dementia. Accommodation is provided on three floors with passenger lift access between floors. There are communal areas on the ground floor, including a lounge and dining room. There were 44 people in the home when we inspected.

There was a registered manager in post. 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.

People's care needs were not always being met as care plans were not always accurate or up to date. This meant people were at risk of receiving inappropriate or unsafe care. The issues we raised at the inspection were acted on promptly by the registered manager who notified us of actions they had taken following the inspection.

Activities for people were limited, particularly for those who chose to stay in their rooms. The activity organiser had been off work for a few months which had impacted on activity provision. The provider acknowledged this and told us of the plans they had to recruit new activity staff in the near future.

Medicines were managed safely. Risks to people were assessed and managed to keep them safe. Staff had been trained in how to identify and report abuse. Records we reviewed showed appropriate action had been taken to keep people safe and safeguarding referrals had been made to the local authority safeguarding team.

Staff were recruited safely and received the induction, training and support they required to carry out their roles. There were enough staff to meet people's needs and keep them safe.

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

The home was clean and staff followed good infection control practices. Checks were carried out regularly to ensure the safety of the premises and any equipment used. The home was comfortably decorated and furnished. However, some areas required improvement to make them more dementia friendly so people living with dementia could find their way around more easily.

People and relatives spoke highly of the staff who they described as kind and caring. We saw staff had developed good relationships with people and knew them well. Staff treated people with respect and maintained their privacy and dignity.

People told us they enjoyed the food. A choice of food and drinks were available at all times. People knew how to make a complaint and we saw complaints raised had been dealt with appropriately.

People, relatives and staff spoke positively about the registered manager and the way the home was managed. There were systems in place to measure monitor and manage the quality of the service. However, we found these needed to improve as issues we identified had not been resolved by the provider until we brought them to their attention. We made a recommendation about improving governance systems.

We identified one breach of regulation in relation to safe care and treatment. You can see what action we have told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely.

Staffing levels were sufficient to meet people's needs in a timely manner. Staff recruitment checks were thorough.

Risks to people's health, safety and welfare were assessed and mitigated. Safeguarding incidents were recognised, dealt with and reported appropriately.

Is the service effective?

Good

The service was effective.

Staff received the induction, training and support they required for their roles.

The service met the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met. People had access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People told us the staff were kind and caring and this was confirmed in our observations.

People were treated with respect and their privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were not always accurately reflected in the care records.

Activities were provided, however these were limited.

People knew how to raise any concerns and a complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Systems were in place to assess, monitor and improve the quality of the service. However, we identified issues which had not been addressed by the provider, until we raised them.

People, relatives and staff provided positive feedback about the way the home was run and praised the leadership and management.

Trinity Fold

Detailed findings

Background to this inspection

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

This inspection took place on 6 November 2018 and was unannounced. The inspection team consisted of three inspectors and an expert by experience with experience of services for older people attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report.

We observed how care and support was provided to people. We spoke with eight people who were using the service, two relatives, seven care staff, one of the housekeeping staff, the chef, the registered manager and the district manager. We also spoke with a visiting healthcare professional.

We looked at five people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Good

Is the service safe?

Our findings

Medicines management was safe. Senior care staff administered medicines. They confirmed they had received up to date medicines training and had had their competency assessed by the deputy manager. This was evidenced in the staff training records we reviewed. Staff had access to policies and guidance, such as the British National Formulary, which provided detailed information about medicines. Regular medicine audits were carried out which identified any issues and showed the actions taken to address them.

Medicines were stored safely and securely. Temperatures of storage areas were recorded and within the required limits. Safe systems were in place for the ordering, receipt and disposal of medicines. Some medicines require additional secure storage and management because of the nature of the drugs they contain. These are known as 'controlled drugs'. These medicines were managed safely.

The registered manager told us no one currently received their medicines covertly (hidden in food or drink). Medicine administration records (MAR) were well completed and included a dated photograph of the person; signed by staff as 'a true likeness'. We checked the balance of some medicines and found the stock count tallied with the amounts recorded. Topical medicines were signed for on a separate chart and were accompanied by protocols using body maps to show staff where to apply prescribed creams and lotions.

Some people were prescribed medicines to be given 'as required' (PRN). When medicines had been prescribed PRN, people were asked if they required the medicine before staff dispensed it. Protocols were in place for each PRN medicine providing guidance for staff about when and in what circumstances the medicine should be given.

There were enough staff to meet people's needs and keep them safe. Care staff were allocated to support people in different areas of the home. Although most people chose to spend the day downstairs in the lounge, some people preferred to stay in their rooms. We saw staff worked well together; ensuring people received the care and support they needed wherever they chose to be.

The registered manager used a staffing tool, which considered people's dependencies, to calculate safe care staffing levels. This was reviewed monthly or more frequently if people's needs changed. The most recent reviews showed staffing hours exceeded the levels recommended in the staffing tool. Care staff were supported by ancillary staff such as catering, laundry and housekeeping staff. The registered manager advised they were in the process of recruiting more care staff. Regular agency staff were employed to ensure continuity of care for people until permanent posts were filled.

People spoke positively about the staffing levels. Comments included: "You have got people around you all the time and staff are very good, the staff make me feel safe. There seems to be enough staff on"; "There's enough staff and they are all lovely" and "There's always somebody knocking about checking on you." However, two people told us there were times in the evening when staff went for their breaks and there were no staff around to help people. We discussed this with the registered manager who advised staff went for their breaks separately in the evening to make sure that there were always staff available. They said they

would check to make sure all staff were following this practice.

Staff told us they felt staffing levels were sufficient to meet people's needs. A healthcare professional who visited the home regularly said there were always staff available when they visited.

People told us they felt safe in the home. Staff had completed safeguarding training, understood how to recognise possible abuse and were aware of the reporting procedures. They were confident any concerns raised would be dealt with appropriately but also knew the external agencies they could contact if they felt this had not happened. Safeguarding incidents were well recorded detailing the actions taken to keep people safe and looked at any wider lessons to be learned. We saw appropriate referrals had been made to the local authority safeguarding team.

Risks to people were well managed. People's care records included risk assessments for areas such as behaviour, falls, nutrition, mobility and skin integrity with guidance for staff on how to manage the risks. We saw technology was used to help reduce risk. For example, where people were assessed at high risk of falls, the use of sensor equipment to alert staff to people's movements.

Staff understood the risks to people and knew the actions to take to keep people safe. Care staff sought to understand, prevent and manage behaviour people displayed that may challenge others. They did this by recording what happened before, during and after incidents to determine triggers to be avoided and actions that helped the person. This aligns well with best practice. Care staff told us about a person who sometimes displayed behaviours that challenged and described the steps they took to prevent occurrences. We saw this was well documented in the person's care plan.

Accidents and incidents were well recorded and included the action taken in response to keep people safe. A monthly analysis was carried out by the registered manager which considered any themes or trends and lessons learned.

New staff were recruited safely with all required checks completed before they started in post. This included application forms with full employment history, job interview, proof of identity, two references and a criminal record check.

The home was clean and hygienic with no unpleasant odours. Hand washing facilities were available throughout the home. Staff understood their roles and responsibilities in relation to infection control and hygiene. One of the housekeepers took the lead in infection control and attended the local authority infection control group meetings where updates were discussed and good practice was shared. This information was then passed on to staff in the home. We saw staff washed their hands and wore personal protective equipment (PPE) such as gloves and aprons appropriately.

Regular and up to date safety checks were carried out on the premises and equipment. This included checks on fire, electrical, gas and water systems and equipment such as hoists.

Staff had received fire training and knew the procedures to follow in the event of a fire. Fire drills were carried out regularly at different times and records showed the staff who had attended. Fire safety checks were carried out regularly and were up to date. Personal emergency evacuation plans (PEEPS) were in place which outlined the support each person would need from staff if they needed to be moved in an emergency situation.

Good

Is the service effective?

Our findings

Pre-admission assessments were carried out by senior staff before people were admitted to the home. Assessments we reviewed considered the individual's needs and choices, the support they required from staff and any equipment needed. This enabled the registered manager to ensure the service could meet people's needs

Staff received the induction, training and support they required to meet people's needs. People we spoke with felt the staff were well trained. Comments included; "[Staff] are well trained, they are lovely"; "Well, I've no complaints, they know how to look after me" and "On the whole they know what they are doing."

We saw records which showed newly employed staff completed the organisation's three months induction programme which incorporated discussions, demonstrations and observations of practice and training. This training was completed alongside the Care Certificate. The Care Certificate provides care workers with standardised training which meets national standards. One staff member, who was new to care, told us they had been well supported through their induction and had learnt a lot from senior staff.

Staff spoke positively about the training they received and confirmed this was kept up to date, which was evidenced in the training matrix we reviewed. This included areas such as moving and handling, infection control, safeguarding and health and safety. Effective recording systems allowed the registered manager and district manager to monitor staff training and identify when it needed to be renewed. The provider also ensured staff had access to further training and development opportunities. For example, one senior staff member was completing a management development programme to progress their career.

Staff told us they felt supported in their roles and received regular supervision, which they found helpful. We saw evidence of these in staff records. Annual appraisals also took place. The registered manager had effective systems in place to monitor these processes.

People were provided with food and drinks which met their nutritional needs and preferences. People told us they enjoyed the food and made the following comments; "It's good is the food"; "I have bacon and eggs for breakfast every morning"; "It's very good food, I like everything" and "They bring me a cup of tea in bed in the morning."

The kitchen had recently re-opened following a six weeks refurbishment which had coincided with the appointment of a new chef. During the refurbishment staff had worked from a temporary kitchen on the first floor.

We spoke with the chef who had a good understanding of people's dietary needs and preferences. Each person had a dietary summary sheet which was updated weekly with a copy kept in the kitchen and another for care staff on each floor. These showed any specific requirements such as, those who should not have grapefruit due to medication they took, those who were diabetic and people who had any dietary allergies. Any specialist dietetic advice was also included such as thickened fluids or pureed food.

We saw the chef was pro-active in ensuring people's needs were met. For example, providing soya milk for one person who preferred this to dairy and prompting a referral to the speech and language therapy team (SALT) for another person who was not eating much and struggling to chew.

New autumn/winter 2018 menus were being introduced. These followed a four-week rotation with plenty of choice available. Snacks were served mid-morning and mid-afternoon consisting of biscuits, homemade cakes and fruit with yogurts. The kitchen was staffed daily from 7am until 6.30pm. Food and drinks were available to people throughout the day and overnight.

People could choose where to have their meals with most people eating in the dining room. We observed breakfast and lunch which was served by the catering staff. Dining tables were set with linen cloths and napkins, flower vases, milk jugs and sugar bowls, cutlery and crockery.
Breakfast was available until 10.30am with people offered a choice of hot and cold drinks, cereal, porridge, toast and bacon and eggs. Several people said how much they looked forward to, and enjoyed, breakfast. There was also a choice of meals at lunchtime. The food looked appetising and hot. People were asked what they would like to have and were shown plates of food to guide this choice. Where people needed assistance, this was provided patiently and sensitively by staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 found the service was working within the principles of the MCA. We saw staff explained what they were doing and ensured people's consent before proceeding. People's care records showed they had signed consent to their care and treatment, unless they lacked mental capacity to make this decision. We saw where mental capacity assessments determined a person lacked capacity to make a particular decision, best interest decisions were recorded. For example, a person was assessed as lacking capacity to make a decision about the use of bed rails; a best interest decision was made by their next of kin and senior care staff. Care staff we spoke with understood mental capacity and the principles of assessment including that people are assumed to have capacity and have the right to make unwise decisions.

The registered manager maintained a tracker of DoLS applications so they could see at a glance when applications had been submitted and approved and when they were due for renewal. Where people had Lasting Power of Attorney (LPA) the registered manager had a copy of the legal documents confirming this was in place.

People's healthcare needs were met. Care records showed visits from GPs, district and specialist nurses and podiatrists. We saw people had been referred to dieticians and speech and language therapists (SALT) in response to assessed risk and /or weight loss. The registered manager had developed good working relationships with health and social care professionals. We spoke with a visiting community NHS nurse. They attended the home frequently and praised staff for referring appropriately, actively seeking advice when necessary and following professional guidance to deliver effective care.

Communal areas were bright, nicely decorated and comfortably furnished. Chairs and settees had been thoughtfully arranged to create small seating areas where people could sit and chat with each other. A family room on the first floor which had been used as a temporary kitchen was being redecorated and refurbished. Bathrooms and toilets were adapted with hoist assisted baths and grab rails fitted next to raised toilets. Signs on doors indicated these rooms. People's bedroom doors were fitted with locks, door bells and letter boxes and had the person's name on the front. Bedrooms we viewed were homely and personalised with belongings people had brought in.

However, we found, where bedrooms were located, the corridors were stark with few pictures or visual landmarks to assist people. Doors and walls were all painted white and all looked the same with only the names on the doors indicting different rooms. Research has shown people living with dementia can benefit from the use of colour, pictures or objects to help them find their way around. We discussed this with the registered manager who, following the inspection, told us they would be discussing this with people who lived in the home to gain their views and suggestions on how to make improvements.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were kind and caring. Comments included: "The staff are ever so nice. Visitors can come when they want"; "The staff are lovely they would do anything for you"; "They are nice lasses, and lads now" and "It's brilliant here. [Staff] are good to me. I like them."

Relatives also praised the staff and the care they provided to their family members. One relative said, "Yes the staff are kind, they obviously care about [family member]. When [family member] was in the hospital I called in and they all asked how [family member] was." Another relative said, "It's good, it's clean and safe, [family member] is well looked after and happy, [family member] loves it here. They all get lots of attention."

We saw staff were respectful in their interactions with people and displayed kindness and compassion. We saw staff took every opportunity to engage with people throughout the day and were pleasant, cheerful and caring.

Staff maintained people's privacy and dignity. People told us staff always rang door bells or knocked on the door before entering their bedrooms and we saw this happening. Staff were mindful of confidentiality, asking people discreetly about their personal care needs and ensuring this was carried out in private. People were dressed in clean and comfortable clothing and had been supported by staff to maintain their appearance. One relative commented on the thoughtfulness of staff saying, "They do things like putting [family member] in a nice scarf because [family member] is going out to church."

Staff promoted people's independence, encouraging and supporting them to do as much as possible for themselves. For example, at lunchtime we saw vegetables were served in tureens on tables so people could help themselves. At breakfast people could pour their own drinks from tea and coffee pots and add sugar and milk from the table. Staff escorted people needing assistance down in the lift while others used the lift independently. We saw staff encouraged people to walk wherever possible. One person used a walking frame to walk to the lift and then went down in the lift in a wheelchair. The staff member said the person would then be encouraged to walk with their frame from the lift to the dining room.

People told us they were consulted in decisions about their care and could make choices such as when to get up or go to bed. One person told us, "We stay up late to play cards, about four of us, until 10.30pm. The others go to bed around 8pm." Other people told us they were supported to have baths and showers when they wanted them. One person said, "I feel safer having a bath with the support of a carer. I have a bath on Tuesday and Saturday." Another person commented, "At home I can only have a shower, here I have a bath it's nice."

People's records included their social history and experiences in a 'Life Story' and staff we spoke with were aware of these details. They knew people's current care needs and preferences and about people's families and who visited them. They knew what made different people happy and what could upset them. We saw staff used this knowledge to adapt their approach according to people's moods and feelings. For example, sitting next to one person who was quiet; talking softly with them and reassuring them. Another person was

more outgoing and we saw them laughing and joking with staff.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. Although some of the care records were detailed and person-centred, others we reviewed did not always reflect people's current needs, contained contradictory information and were not up to date.

For example, one person's communication care plan stated they had no visual difficulties, yet the initial assessment showed the person had glaucoma. The initial assessment stated the person was a non-practising Catholic. However, the care plan said the person used to go to church every Sunday, would like to have Holy Communion in their room and wanted to be informed when the priest visited. Staff told us these visits would be recorded in the activity records. We looked at activity records for this person from 9 July to 4 November 2018 and there was no evidence to show a priest had visited or that the person had received holy communion.

Another person's care records showed they had had several falls and a falls risk assessment had been completed. However, there was no falls prevention plan and, although this person had sensor equipment in their bedroom to alert the staff to their movements, it was unclear how this decision had been reached. A capacity assessment noted the person had the capacity to make this decision. However, there was no evidence the person had been consulted and the capacity assessment was signed by a staff member and the person's relative, but not the person involved.

The care records for one person living with dementia showed the person was losing weight. Staff told us the person had started to refuse food and was sometimes anxious as they thought they had to pay for the food. Daily records showed the person was refusing assistance with personal care, reluctant to take diet and fluids and had been exhibiting some behaviour that challenged others. This was not reflected in the person's care plans and it was unclear what steps had been taken to address these concerns. This meant there was no clear guidance for staff about the support and care this person required. Following the inspection, the registered manager told us of the action they had taken to address these matters.

One person had been receiving end of life care for several months. We visited the person in their bedroom and they looked comfortable and well cared for. The lighting was dimmed and classical music was playing, which a staff member said the person enjoyed. The person's care records reflected their wishes to stay at the home and not be taken into a hospital or hospice. Charts showed the person was being repositioned every four hours to keep them comfortable and reduce the risk of developing pressure ulcers. However, one staff member told us they thought the person may be in pain when they were being moved because of the sounds and grimaces they made. We spoke with a senior staff member who said they were not aware the person was ever in pain. The person was prescribed anticipatory medicines, including pain relief but staff said these medicines would be given by community nurses if they were needed. The person was not prescribed any other 'as required' pain relief for care staff to administer. There were no assessments in place to determine whether the person was in pain or displaying any symptoms which would indicate the anticipatory medicines should be administered. Senior staff were not aware the person may be experiencing pain and therefore no 'as required' pain relief medicine had been requested or medical review

sought. The registered manager took immediate action to address these issues when we raised them. They put a pain assessment chart in place to monitor the person's condition and spoke with all staff about communicating any changes in the person's condition.

We concluded the evidence above showed people were not always receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some activities were taking place these were limited and not everyone was given the opportunity to participate in meaningful activities. The provider employed an activity organiser, however they had not been at work since May 2018. This had impacted on the activity provision at the home. The registered manager told us one of the housekeeping or care staff was allocated to carry out activities each day. However, they did not record which activities had taken place or who had participated. This was left to care staff to document who, if they were working elsewhere in the home, were often not aware what activities were taking place or who had joined in. We reviewed the activity records for 12 people for the week prior to the inspection. Apart from visits from relatives, watching TV or listening to the radio, one person, on one occasion had been recorded as playing dominoes. Most people spent their time 'socialising in the lounge'. Staff said children from a local nursery visited the home twice a week and, "residents love it." This was not reflected in the activity records.

One person told us they played cards and games with four or five other people several nights a week but they organised this themselves. Care staff said a church service took place once a month. They said no records were kept about outings or who engaged with church services.

The service had previously received an award from Calderdale Corporate and Community Trust following their involvement in an arts project with local nursery schools.

On the day of inspection, the staff member organising activities took some people in a taxi to an exercise class which was being held in a local sheltered accommodation building. One person who attended told us, "I have been to exercises this morning we had a good laugh." In the afternoon we saw a small group of people enjoyed taking part in a quiz in the lounge.

In the lounge an internal window had been decorated for Remembrance Day. The poem 'In Flanders Fields' was written next to a silhouette of a soldier, which had been done by a relative, surrounded by poppies made by people living in the home. Some people told us they were going with staff to view the wreaths displayed in Halifax.

People and relatives told us there had been fewer activities following the absence of the activity organiser. Comments included; "We do some things. They are going to do more but the activity person is off. I like quizzes and bingo" and "There used to be a lot of activities but [activity organiser] has been off. My family take me out." One person told us; "There are no activities. No one comes to do activities or talk to me in my room." A relative said, "The children come from Eureka, she loves that. She lovers the singers and the games. We did a Family Fortunes thing with some residents and families."

The district manager told us of the provider plans to improve activities which included increasing the home's activity budget and advertising for an active wellness co-ordinator on 12 November 2018. They were also looking to appoint two activity champions, two exercise champions and two Ipad champions. All champions would receive in-depth training and support and work with the wellness co-ordinator to develop better community links, book external activities and plan daily activities, including one-to-one activities for

people in their rooms.

People and relatives we spoke with knew how to make a complaint and felt confident any issues raised would be dealt with appropriately. One relative told us they had raised some minor concerns with one of the staff and said these had been sorted out. One person raised a concern with us which they had also raised with the registered manager who was carrying out an investigation. The complaints log showed six complaints had been received since 9 February 2018. Records showed the detail of the complaint, the outcome and written response to the complainant. The information seen indicated any issues raised were taken seriously and investigated in a timely way.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post who had worked at the service for many years. They were supported in their role by a deputy manager and team leaders.

People and relatives we spoke with were happy with the management of the service. Comments included; "It's super, really good. A relative of mine who visits here says it's the best care home she has ever visited, and she has been to lots"; "It's an extremely good care home, I feel safe because of the care, look people are happy and talking to one another" and "The organisation makes you feel safe, it's well organised."

Staff told us they were happy working at the service and felt well supported by colleagues, team leaders and managers. They all said if they had any issues they would not hesitate to share them with the registered manager and were confident she would listen and act accordingly.

There were processes in place to measure, monitor and improve the quality of the service. A range of quality audits were undertaken. We saw recent audits relating to medicines, care plans, infection control, the environment and health and safety. These evidenced that issues were being identified and action plans were in place to address them. The district manager visited monthly and their most recent report dated 2 November 2018 identified improvements to be made and timescales for completion. However, there were issues we identified during the inspection which had not been identified or addressed by the provider's own systems. We recommend the provider takes action to ensure governance activities are sufficiently robust to ensure required improvements are made.

Staff meetings were held monthly for both day and night staff. Meeting minutes we reviewed showed a wide range of topics were discussed with the emphasis on continuous improvement for people living in the home.

Resident and relatives meetings were held regularly giving people an opportunity to air their views. We saw minutes from the meeting held in August 2018 which showed what people had said and the action taken to address any issues raised. A further meeting was scheduled for a few days after the inspection.

The home worked in partnership with the local authority to secure improvements for people living in the home. We received positive feedback from the local authority who had carried out monitoring visits to the home. Effective working relationships were also established with health and social care professionals.

Satisfaction surveys had been sent out last year to people who lived in the home and relatives. Any areas for improvement were followed up at resident and relative meetings and in audits to make sure they were actioned.

The previous inspection ratings were on display in the home and on the provider's website as required under legislation.

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 Care plans did not always contain accurate and up to date information to enable staff to provide care safely. Regulation 12 (1)