Amore Elderly Care Limited

Abbey Court Care Home

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

Overall summary

Abbey Court Care Home provides residential and nursing care for up to 88 older people, including people living with dementia. The home is purpose built and is divided into four wings. On the ground floor up to 17 people live in the Residential wing and up to 19 people live in the Nursing wing. The first floor is reserved for up to people living with dementia. Upstairs, up to 31 people live on the East wing and up to 21 people on the West wing. There were 86 people living in the home on the day of our inspection.

Our last full inspection of the home was conducted in February 2015. At that inspection we identified a breach of legal requirements relating to care staffing levels. We also identified a number of other areas where improvement was required, including medicines management and protecting people's privacy. In October 2015 we conducted a focused follow up inspection to review care staffing levels specifically and found that the provider was no longer in breach of legal requirements in this area.

Summary of findings

We conducted this further full inspection of the home on 9 March 2016 to check what progress had been made since February 2015. The inspection was unannounced.

The service had a registered manager ('the manager') in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider'), 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.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of the inspection the provider had submitted DoLS applications for 51 people living in the home and was waiting for these to be assessed by the local authority.

During our inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not managed consistently in line with good practice and national guidance and some people were not protected properly from the risk of falling. You can see what action we told the registered person to take at the end of the full version of this report.

We also found that some staff did not have the necessary skills and knowledge to meet the needs of people living with dementia. We have made a recommendation about staff training in this area.

Although staffing levels were sufficient to meet people's personal care and support needs, further action was needed to ensure people had sufficient stimulation and occupation.

People or their relatives were not offered the opportunity to be involved in the review of people's individual care plan and the provider's audit and quality monitoring systems were not consistently effective.

We did find some areas in which the provider was meeting people's needs effectively.

Food and drink were provided to a good standard and people had prompt access to any specialist healthcare support they needed.

The provider had sound recruitment procedures in place and formal complaints were well-managed. The manager had an open and supportive leadership style and met regularly with people and their relatives to discuss any concerns or suggestions.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

The management of people's medicines was inconsistent and was not always in line with good practice or national guidance.

People's individual risk assessments were not effectively reviewed and updated which meant some people were not protected properly from the risk of falling.

Sound recruitment processes were in place.

Requires improvement

Is the service effective?
The service was not consistently effective.

Some staff did not have the necessary skills and knowledge to meet the needs of people living with dementia.

People had prompt access to any specialist healthcare support they needed.

Food and drink were provided to a good standard.

Requires improvement

Is the service caring?
The service was not consistently caring.

Some staff did not support people in a way that promoted their privacy and dignity.

People's personal information was stored confidentially.

Requires improvement

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

People or their relatives were not offered the opportunity to be involved in the review of people's individual care plan.

People were not provided with sufficient occupation and stimulation and the needs of people living with dementia were not fully met.

Complaints were well-managed.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

Requires improvement

Summary of findings

The provider had failed to make some of the improvements identified at our last full inspection.

The provider's audit and quality monitoring systems were not consistently effective.

The manager had an open and supportive leadership style.

The provider met regularly with people and their relatives to seek their feedback on the service provided.

Abbey Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was 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.

We visited Abbey Court Care Home on 9 March 2016. The inspection team consisted of two inspectors and a specialist advisor whose specialism was nursing care of people living with dementia.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with four people who lived in the home, six visiting friends and family members, the manager, seven members of the care staff team, one member of the activities team and the catering manager. We also spoke with two local healthcare professionals who had regular contact with the home.

We looked at a range of documents and written records including 20 people's care records, staff training records and two staff recruitment files. We also looked at information relating to the administration of medicines, staff supervision, managing complaints and the auditing and monitoring of service provision.

We reviewed other information that we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies.

Requires improvement

Is the service safe?

Our findings

People we talked with said they felt safe living at Abbey Court. One person said, "Yes, I feel safe. The staff come in at night and check on me." A visiting relative told us, "I trust the staff implicitly."

However, when we reviewed the arrangements for the storage, administration and disposal of medicines we found that these were not managed consistently throughout the home and presented an increased risk to people's safety. Although we found sound practice in some units, in others the management of people's medicines did not reflect good practice and national guidance. For example, when we talked to one person they told us that they had been asleep when staff came round with their medicines on the morning of our inspection. The person appeared happy with this approach and told us something similar had happened previously. However, a staff member had signed the person's medicine record to indicate the medicines had been administered when they could not have been certain whether they had been taken or not. Additionally, during the time the person was asleep the medicines could have been taken by someone else. We also saw that that the door to the medicines storage room in one unit was unlocked and the medicines fridge within the room was also unlocked. This meant that prescription medicines could have been accessed by staff who were not authorised to handle medicines and by anyone passing by on the corridor, including people living in the home. We discussed this issue with the unit leader who told us that the key to the storage room had broken off in the lock the day before our inspection and had not yet been repaired.

Although there was no evidence that people had come to any harm, these errors in the management of medicines increased the risk to people's safety. At our last full inspection of the home in February 2015 we also identified shortfalls in medicines management and advised the provider at that time that improvement was required.

The provider's continuing failure to ensure consistent medicines management within the home was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In preparation for our inspection visit we reviewed the notifications (events which happened in the service that the provider is required to tell us about) we had received from the provider in the previous 12 months. These included seven serious injuries requiring hospital treatment sustained by people as a result of falls. During our inspection visit we looked at people's care records and saw, when someone first moved into the home, staff assessed a wide range of possible risks to the person's wellbeing, including the risk of falling. However, some people's risk assessments were not effectively reviewed and updated to keep them safe from harm. For example, in March 2014 one person had been assessed as being at high risk of falls and several preventive measures were identified for staff to follow. However, in the period from August 2014 to March 2016 this person fell 28 times, sustaining injuries to their head on at least two occasions. Throughout this period senior staff had conducted a monthly review of the person's mobility risk assessment but, despite the continuing falls, no additional or alternative preventive measures had been identified, even though there was a section on the provider's risk assessment template for this to be done.

In another example, a visitor told us that their relative had fallen on a number of occasions. When we looked at this person's care plan we saw staff had assessed them as being at high risk of falls. However, there were no preventive measures identified to try to reduce the risk and no evidence that the risk assessment had been updated in response to the falls that had occurred.

The provider's failure to protect people consistently from the risk of falling was a breach of Regulation 12 (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider maintained a number of systems to ensure the building and equipment were safe for people, staff and visitors. These included a regular 'environmental audit' conducted by a senior member of staff and a monthly 'Safety, quality and compliance' meeting chaired by the manager. However, despite this focus on health and safety, on the day of our inspection we found the housekeeper's storage cupboard on one unit was open, despite a prominent sign on the door which read, 'Please ensure door is locked at all times'. The cupboard contained hazardous chemicals and although the manager immediately arranged for it to be locked, this lapse in health and safety procedures had created an increased risk to the people living in the home.

Requires improvement

Is the service safe?

Other risks to people's welfare were managed more effectively. For example, we saw that some people had been assessed as being at risk of developing skin damage. The provider had sought specialist advice and a range of preventive measures had been put in place which were understood and followed by staff. The provider had also assessed the risks to each person if there was a fire or the building needed to be evacuated. This information was available to all staff together with a 'grab pack' containing equipment such as torches and high visibility jackets which might be required in an emergency.

We saw the provider had safe recruitment processes in place. We examined two staff personnel files and saw that references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the service had employed people who were suitable to work with the people living in the home.

At our last full inspection in February 2015, we found that the provider was in breach of legal requirements as there were insufficient care staff employed in one of the units of the home. The provider took immediate steps to increase care staffing levels and during this inspection we saw that this increase had been sustained. People told us that care staff had time to meet their personal care needs without rushing. One person said, "Staff come quickly if I need them." Another person told us, "There is always someone about." Some people's relatives told us they had worries about staffing levels at night. When we raised this issue with the manager he told us he had recently conducted a 'surprise' night visit to the home and was confident that night-time staffing was also at the right level.

Staff were clear about to whom they would report any concerns relating to people's welfare and were confident that any allegations would be investigated fully by the provider. Staff said that, where required, they would escalate concerns to external organisations. This included the local authority safeguarding team and the Care Quality Commission (CQC). Staff had received training in this area and policies and procedures were in place to provide additional guidance if necessary.

Requires improvement

Is the service effective?

Our findings

The provider maintained a detailed record of the training needs of each member of staff and employed an in-house trainer to deliver much of the core training required. The provider also worked with a range of other agencies, including the local authority and equipment manufacturers, to provide staff with specialist training in areas including infection control and end of life care.

New staff participated in a structured induction programme followed by a period of shadowing senior staff before they started to work as a full member of the team. One member of staff told us, "The induction programme prepared me well. I didn't have any problems." The provider had embraced the new national Care Certificate which sets out common induction standards for social care staff and had built this into the induction programme for new recruits. Staff were also provided with regular supervision and an annual appraisal.

However, despite the provider's systematic approach to staff training and support, people we spoke with had mixed views about the ability of staff to meet people's needs effectively. One family member told us, "The staff do an outstanding job." But others expressed concerns about the skills of staff, particularly in supporting people living with dementia. One relative told us they thought some staff lacked knowledge and experience in this area. Another relative said, "They are so kind and caring but some could do with more knowledge. Maybe they should go on a course." During our inspection visit we observed situations in which some staff appeared to lack insight and knowledge in how to support people living with dementia. For example, at lunchtime we saw staff offer people a choice from the two main meal options on the menu. However, some people living with dementia clearly found it difficult to make a choice or did not respond to a verbal prompt. When one person did not indicate a choice, a staff member said they would "give them a little bit of each" rather than using alternative approaches to help the person choose their meal. On another occasion, whilst discussing the activities programme with one of the specialist activities coordinators, they told us, "We don't do anything particular around the needs of people with dementia. Most people here have some form of dementia but we haven't got anyone who needs 'proper' dementia activities." Invited by our inspector to explain what 'proper' activities might be, the activities coordinator was unable to offer any examples.

We discussed this issue with the manager who told us that the provider had recognised the need to improve staff training in this area. A new three-day 'creative minds' course had been developed and was being delivered to all staff by members of the provider's national training team. The manager told us that "around 60-70%" of staff at Abbey Court had completed the course which meant there was a significant number of staff working in the home who were still to benefit from the additional training. The manager also said that he was concerned that some staff lacked knowledge in how to support people who could be aggressive towards others. He told us of one recent incident in which some staff had been unable to effectively support someone whose behaviour had become challenging to the staff and other people living in the home. As a result of this incident, the manager said he was arranging specialist 'conflict management' training for some staff.

In the light of our findings, we recommend that the provider finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

Staff were aware of the Mental Capacity Act 2005 (MCA). This 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). At the time of our inspection the provider had applied for a DoLS authorisation for 51 people living in the home to enable them to continue to receive the care and support they needed, whilst ensuring that their rights were protected.

Requires improvement

Is the service effective?

We also saw that, when required, senior staff organised meetings with people's families or professionals involved in their care to agree what was in a person's best interests, if they were unable to make the decision for themselves.

Staff ensured people had access to local healthcare services whenever they needed them. From talking to people and looking at their care plans, we could see that people's healthcare needs were met through the involvement of a wide range of professionals including GPs, community nurses, chiropodists and community psychiatric nurses. For example, one person who had recently moved into the home had been assessed by staff as being at risk of malnutrition. A referral had been made to the local Speech and Language Therapy service to ensure staff had access to specialist advice to assist them support the person effectively. A relative told us, "Staff are very quick to identify any health issues and keep me informed of any change in [my relative's] condition." One local healthcare professional told us, "The service has improved a lot over the last year. Staff are very helpful and on the ball and we have no worries or concerns."

People told us they enjoyed the food and drink provided in the home. One person said, "The food is smashing. There's plenty of it. Too much really!" Another person said, "I always enjoy my meals." We observed people eating lunch and snacks and saw that they were served food and drink of good quality. The menu changed seasonally and provided people with a choice of options for each of the three main meals of the day. Afternoon tea was also served every day providing a choice of hot or cold drinks and snacks, including fruit and homemade cakes. The catering manager told us that people would always be provided with an alternative if they did not want any of the choices on the menu. For example, the day before our inspection the catering manager told us staff had prepared omelettes for two people who didn't want either of the main lunch options. One person told us, "We can ask for something different if we don't like what's on the menu. Once I didn't really like what was for tea so they asked me what I would like and I had poached eggs instead."

Catering staff had a detailed understanding of the nutritional assessment that had been completed for each person and used this information when preparing food and drink. For example, staff knew who needed to have their food pureed to reduce the risk of choking. Staff were also aware of the needs of people with particular dietary needs, including one person who was following a gluten free diet. One visitor told us that staff had arranged for their relative to have nutritional supplements as they had lost a lot of weight. They said, "[My relative] loves the supplements and is looking so much better."

The catering manager told us that he encouraged people to provide feedback on the food and drink provided. He said, "I speak to people and their relatives every day and ask for their feedback. Some people told me we were having chips too often so now we have more mashed potato on the menu. We used to do chicken nuggets but now we do chicken goujons as people said they preferred them." The manager told us that he had asked the catering manager to attend the provider's regular relatives' meetings to gain additional feedback and suggestions on the menu. We also saw that there was a photograph of the catering manager in the main reception area, inviting people to contact him with any comments about the food and drink service in the home.

Requires improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, “The staff are lovely. I can’t find any fault. They definitely care.” Another person told us, “It’s brilliant. The staff are very pleasant.” One visiting relative said, “The staff are very calm. They are kind and attentive.”

Following our last full inspection of the home we reported that staff did not always respect people’s dignity and privacy. Although we had advised the provider at that time that improvement was required, during the course of our inspection visit we found that some people were still not supported in a way that maintained their dignity and privacy. We observed that some staff did not knock before entering people’s rooms, including on one occasion when one of our inspectors was talking to someone in their room with the door closed and a member of staff entered the room without knocking. When the staff member saw that the person was talking to our inspector they apologised and withdrew. But they then returned a few minutes and did exactly the same thing again. We discussed this incident with the manager who acknowledged our concerns and agreed that further action was required to ensure that people’s dignity and privacy was maintained at all times.

Staff supported people in a friendly, person-centred way. For example, we saw one member of staff engaging with someone who was becoming slightly upset. The staff member spoke with them in a gentle and reassuring way which helped reduce the person’s anxiety. On another occasion we saw a member of staff taking time to patiently support someone to enjoy a glass of squash, chatting cheerfully with them throughout. Describing one person who was leaving the home shortly to live nearer to their family, a staff member said, “Even though it’s better for them, we’ve taken them under our wing and we’ll be sad when they go.” One person told us, “One of the care staff has ‘adopted’ me as their Mum. They came in one morning and gave me a cuddle.” This warm, tactile approach was clearly appreciated by the person concerned.

Staff also understood the importance of giving people as much choice and control over their life as possible. For example, one staff member told us about one person they supported who was keen to walk independently. The member of staff said, “Although it takes much longer, I always take the time to encourage them to walk on their own.” Describing another person, one staff member told us, “One person likes to shave his beard but keep his moustache. We all like our own way of doing things.”

A local vicar attended the home on a monthly basis to conduct a religious service that was attended regularly by some people. One member of staff told us, “It is really nice when the vicar comes in. If people are poorly he will visit them in their rooms.” Staff also told us that, if necessary, they would make specific arrangements for people of alternative faiths to ensure their individual spiritual needs were met.

The provider had taken steps to ensure people’s personal information was stored securely and computers were password protected to ensure confidentiality.

Although the provider did not give people information on local advocacy services, the manager was aware of local services and could advise people on how to access them if they wished. Advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes.

Requires improvement

Is the service responsive?

Our findings

If someone was thinking of moving into the home the manager told us that a senior staff member normally visited the person to carry out a pre-admission assessment to ensure that Abbey Court could met their needs. When someone moved in, staff then prepared a personal care plan detailing the person's individual preferences and requirements. The manager told us he expected this to have been completed "within two or three days" of the person moving in.

People we spoke with had mixed experiences of the level of involvement they had had in the development of their plan. One person told us, "Yes they had me in the office and I signed the papers." But one person's relative told us that they had not seen their plan. Additionally, although we saw that the completed care plans were reviewed regularly by senior staff, in some people's files there was no evidence that people or their families had been given the opportunity to be involved in these reviews.

People's care plans were prepared with a standard template that the provider used in all of its homes. The template was extremely detailed and was designed to record each person's needs and preferences in a wide range of areas including mental capacity, mobility and nutrition. However, we saw that there were gaps in some people's plans, particularly in respect of the person's life history. For example, the provider expected staff to use a 'life story' tool to "collect the personal stories… funny stories and sad stories that that are all part of what makes the person who they are today." Staff had not undertaken this exercise with some people, depriving them of important information that could have helped them better understand and respond to people's social and emotional needs in addition to their personal care requirements.

Other needs had been assessed more effectively. For example, one person had been identified as being unable to communicate verbally. The person's care plan included detailed advice for staff to follow when supporting them, including how to interpret their body language.

The provider had established a specialist activities team to take the lead in organising communal activities and supporting people to pursue personal hobbies and interests. There were two activities coordinators employed in the team working a combined total of 80 hours each week, Monday to Friday. The activities coordinators did not work at weekends although one of them told us, "We supply each unit with DVDs and craft activities for the care staff to use." The activities coordinators had developed a weekly activities programme, although this did not vary from week to week. The programme included craft activities, board games and exercise sessions. In addition, there was an annual events programme which including regular musical entertainments.

The activities coordinators told us that they maintained regular contact with people who were unable to join in communal activities, chatting or playing a game together. However, there was very limited evidence that people were supported to pursue personal interests or hobbies that had been important to them before they moved into Abbey Court. One of the activities coordinators told us that there was no one living in the home currently who was a member of a local club or remained active in their local community. The activities team did organise regular group outings to local attractions, although the number of people who could participate in these outings was restricted as the only staffing support available was the two activities coordinators themselves. For example, on the day before our inspection the activities coordinators had led an outing to a local shopping centre but only two of the 86 people living in the home that day had been able to go.

Although both activities coordinators were enthusiastic and committed in their approach, it was clear from some people's comments to us on the day of our inspection that they were finding it difficult to provide sufficient stimulation and occupation to over 80 people. One person said, "There is nothing to do. I love to be outdoors. I used to do my gardening." One person's relative told us, "There is not enough going on for people." Several people told us they particularly enjoyed the outings but were frustrated at the limitations on the number of people who could go at any one time. Throughout our inspection visit, although we did see the activities team interacting with some people on an individual and group basis, we also saw many people sitting for long periods with little or nothing to occupy them.

Some visiting relatives also commented on the provision of activities for people living with dementia. One relative told us, "There are activities but they are not appropriate for the people [living on this unit]. I feel if only they were occupied there would be less problems."

Requires improvement

Is the service responsive?

People were encouraged to personalise their room and we could see that some people had their own photographs and other souvenirs on display in their bedroom. Some people had fresh flowers and pot plants in their room. The doors to each person's bedroom were in a traditional 'front door' style and were painted in a variety of colours, although people did not have the opportunity to choose the colour for themselves. People had their name on their bedroom door and, in the two units for people living with dementia, 'memory boxes' which were designed to help people find their way to their own room. Sadly, many of these were empty. People had access to a wide variety of communal lounges and a secure garden area which staff told us people made regular use of in the warmer months.

Information on how to raise a concern or complaint was provided for people in a booklet that was given to them when they first moved into the home. The provider kept a log of any formal complaints received and we could see that these had been handled correctly in line with the provider's complaints policy. The manager told us that he reviewed each case to identify if any lessons could be learned for the future. For example, following one recent complaint the manager had made changes to the way in which staff supported people who had to go to hospital on an emergency basis.

Requires improvement

Is the service well-led?

Our findings

People told us that they thought the home was well-led. One person said, "Other care homes are nothing compared to this." Another person told us, "They look after you in every way. It's never too much trouble to get you what you want. People also said that they felt the home had improved under the leadership of the current manager who had taken over in March 2015. Speaking of the manager one relative said, "That man needs a medal. He is wonderful." Another said, "The home has got better over the last few months."

Throughout our visit the manager demonstrated an open and supportive leadership style which was clearly appreciated by staff and set the cultural tone for the home. The manager told us, "When I first came here the culture was very closed. Now it's a lot more open and people will raise any issues of concern. My door is always open." One junior member of staff told us, "I can ask [the manager] if he has a few minutes and, if he is busy, he will always make an appointment. I know he will look into any issue I raise, as best he can." Another member of staff said, "[The manager] is brilliant. Things have definitely changed since the manager and his deputy came. If you ask them to do something they will do it." Reflecting on his first year in post, the manager said, "Although there is always more you can do, it's 100% better than it was. When I go home at night I feel a lot more comfortable and confident than I did six months ago."

However, although progress had been made since our last full inspection of the home in February 2015, particularly to increase and maintain staffing levels in the care team, the provider had not achieved all of the improvements we had identified as being required at that time. For example, the management of medicines still did not reflect good practice and national guidance and some people's privacy was still not fully protected.

Although the provider maintained a comprehensive programme of audits to monitor the quality of the service provided at Abbey Court, these were not consistently effective. For example, regular care plan audits were undertaken but these had not picked up the gaps we found in some people's plans. Other audits were more effective. For example, a recent kitchen audit had identified a problem with one of the ovens that was in the process of being addressed.

We saw that staff worked together in a friendly and supportive way. The manager told us, "I am proud of my staff. They work really hard." One member of staff said, "Staffing levels have improved and staff sickness rates have gone down which means we are not tired or stressed. Morale is much higher now." Another staff member told us, "This is my first job and I am really enjoying it. There's a good atmosphere in the staff team. I always feel listened to." There were regular staff meetings which staff said they found helpful for talking through any issues. One staff member said, "We have regular staff meetings on our unit and I always feel I can speak my mind. We recently had a meeting when we decided to make some changes to the way staffing is organised on the unit." Staff knew about the provider's whistle blowing procedure and said they would not hesitate to use it if they had concerns about the running of the home that could not be addressed internally.

The provider undertook regular surveys of people and their relatives to measure satisfaction with the service provided. The surveys were organised by the provider at national level and the manager told us he was waiting for the results of the most recent one which he would analyse to identify any action required in response to the feedback received. The manager told us that he had stopped organising communal meetings with the people who lived in the home as they, "Didn't really work." However he had introduced a 'Thoughts and Feelings' system operated by the activities coordinators who met each person for a quarterly one-to-one discussion to seek their comments on the service they received. The manager told us that he acted on any feedback received from these meetings. For example, one person had asked for more choice on the menu and he had followed this up with the catering manager.

The manager did organise communal meetings with people's relatives to discuss any issues or suggestions relating to the running of the home. These were clearly appreciated by the people who attended. One visiting relative told us, "You do feel that you can speak up." The manager said that he found these meetings increasingly helpful in providing him and his team with feedback. For example, relatives had asked if wi-fi internet access could be provided in the home and this was now in hand. The manager said that he also encouraged relatives to come and see him personally if they had any issues or concerns.

Requires improvement

Is the service well-led?

The provider maintained logs of any untoward incidents or events within the service that had been notified to CQC or other agencies. The manager told us that he had reviewed the outcome of one recent case carefully, in discussion with some of the staff members involved, to try and identify any lessons that could be learned for the future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have suitable arrangements in place to ensure that risks to people's health and safety, including those associated with the unsafe management of medicines, were minimised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have suitable arrangements in place to ensure that risks to people's health and safety, including those from falling, were minimised.