Moreland House Care Home Limited

Moreland House Care Home

Inspection report

5 Manor Avenue
Hornchurch
Essex. RM11 2EB
Tel: 01708 442654
Website: www.morelandcarehome.co.uk

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 23 and 24 September 2015 and was unannounced on 23 September 2015.

Moreland House is a purpose built 50 bed care home providing accommodation and nursing care for older people, including people living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. When we visited 26 people were using the service. This was because in December 2014, when building work had been completed, Moreland House changed its registration from a 20 bed home providing personal care and accommodation for older people to a 50 bed home providing nursing and personal care or older people. The provider limited admissions to the service during the transition period.

We found that the arrangements for administering medicines were not always safe. Medicines records were not always accurate and we could not be confident that people received all of their prescribed medicines safely.

The systems in place to safeguard people from abuse and improper treatment were not effectively implemented.

Summary of findings

People were supported to receive the healthcare that they needed. A healthcare professional told us, “From a medical point of view they are getting good support.”

People told us they felt safe at Moreland House and that they were supported by kind, caring staff. One person said, “Girls are marvellous. Make sure we’re safe.”

We saw that staff supported people patiently, with care and encouraged them to do things for themselves. Staff knew people’s likes, dislikes and needs and provided care in a respectful way.

The provider’s recruitment process ensured that staff were suitable to work with people who need support.

Systems were in place to ensure that equipment was safe to use and fit for purpose. People lived in a clean, safe environment that was suitable for their needs.

Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People told us that the food was good and that they had a choice of food and drinks. We saw that people’s nutritional needs were met. If there were concerns about their eating, drinking or weight, this was discussed with the GP and support and advice were sought from the relevant healthcare professional. For example, a dietitian.

Staff received the training they needed to meet people’s overall needs. However they were not clear as to the action to take in the event of a person choking.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

The arrangements to meet people's social and recreational needs were limited. However this had been recognised by the provider and an activities worker had been recruited.

People’s care plans were being reviewed and updated to ensure that they contained all of the necessary information to enable staff to support them safely and effectively.

The service did not have registered manager but appropriate interim arrangements were in place. The service had not been consistently well managed but people were positive about the changes and improvements that were now taking place.

The provider had systems in place to monitor the service provided and people were asked for their feedback about the quality of service provided. However **we recommend that the provider monitoring reports clearly indicate any action required along with timescales for completion. Also that subsequent visits check and report on the progress made to complete the actions**.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of the care provided were safe. People were placed at risk because the system for administering and recording medicines was not robust.

Risks were identified and systems put in place to minimise risk in order to ensure that people were supported as safely as possible.

Staff were trained to identify and report any concerns about abuse and neglect. However the systems to safeguard people from abuse or improper treatment were not always robustly applied.

There were sufficient staff on duty to meet people's needs.

The provider's recruitment process ensured that staff were suitable to work with people who need support.

The premises and equipment were well maintained to ensure that they were safe and ready for use when needed.

Is the service effective?

Good

The service provided was effective. Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff team had the training they needed to ensure that they supported people safely and competently.

People told us that they were happy with the food and drink provided. They were supported by staff to eat and drink sufficient amounts to meet their needs.

People's healthcare needs were identified and monitored and referrals made to other healthcare professionals when needed.

The environment met the needs of the people who used the service. It had been designed to support people living with dementia.

Is the service caring?

Good

The service provided was caring. People were treated with kindness and their privacy and dignity were respected.

Staff supported people in a kind and gentle manner and responded to them in a friendly and patient way.

People received care and support from staff who knew their likes and preferences.

Staff provided caring support to people at the end of their life.

Summary of findings

Is the service responsive?

Not all aspects of the care provided were responsive. Care plans did not always give sufficient detail to ensure that people received care and support that fully met their current needs. However, these were being reviewed and updated.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Activities, entertainment and trips out were limited but an activity worker had been recruited to address this issue.

Requires improvement

Is the service well-led?

The service was not consistently well-led. However, feedback about the interim manager and the changes made were positive.

Staff told us that the interim manager was accessible and approachable and that they felt well supported.

People were consulted about changes to the service and the provider was available to answer their questions and concerns.

The provider sought people's feedback on the quality of service provided and their comments were listened to and addressed.

Systems were in place to monitor the quality of service provided. We have recommended that required actions identified during monitoring visits are clearly recorded and that subsequent visits check and report on the progress made to complete the actions.

Requires improvement

Moreland House 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. 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 23 and 24 September 2015 and was unannounced on 23 September 2015.

The inspection team consisted of one inspector, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we also reviewed the information we held about the service. We contacted the commissioners of the service to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with four people who used the service, the deputy manager, the provider, one nurse, two senior carers, two carers, the chef, two domestics, six relatives and two healthcare professional. We looked at six people's care records and other records relating to the management of the home. This included three staff recruitment records, duty rosters, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Requires improvement

Is the service safe?

Our findings

People who used the service told us that Moreland House was a safe place to be. One person said, "Girls are marvellous. Make sure we're safe." Another told us, "Oh yes we do feel safe." Relatives also felt that people were safe. One commented, "Yes, very safe. Chosen for safety. Another said, "No problems with safety."

However, we found that not all areas of practice were safe. The systems in place to ensure that people received their prescribed medicines safely and appropriately were not robust. Appropriate action had not always been taken when possible abuse had occurred and the systems in place to deal with emergencies were not robust.

Medicines were not always kept safely. Medicines were stored in appropriate locked medicines trolleys in the nurse stations. The person responsible for the administration of medicines kept the keys with them during their shift. In one unit we saw that the medicines trolley was secured to the wall when not in use but in the other unit this was not the case. There were also storage facilities for controlled drugs (CD). However, we found that the CD cupboard was not secured to the wall but sitting on the floor. In one unit we saw that the staff administering medicines locked the trolley when they left it to give people their medicines. In the other unit this was not the case. Therefore the arrangements for storing medicines were not robust.

Appropriate arrangements were in place in relation to the recording of medicines but these were not consistently implemented. We looked at a sample of Medicines Administration Records (MAR) on each unit. In some cases we saw that the MAR had been appropriately completed and were up to date. For others we saw that the MAR was not always signed. In one case the tablets were no longer in the medicines administration aid but there were gaps on the record. For another person we saw that medicines for three days were still in the pack. We subsequently established that the person had been in hospital for two of the days but the reason for this was not recorded on the MAR. In addition some people were prescribed a variable dose of medicines, for example one or two tablets. In one unit we found that the number given was recorded. However in the other unit this was not the case. This meant that there was not an accurate record of the medicines that people had received. We could not be confident that they had received all of their prescribed medicines which was a risk to their health and welfare.

For some people there were guidelines in place for the administration of 'when required' medicines but for others there was not. This meant that staff did not always have clear information as to when and how to administer this. Therefore people were placed at risk of not receiving these medicines appropriately or effectively.

The provider had systems in place in the event of an emergency. However, although they had received first aid training none of the four staff we asked were able to give the full safe protocol when asked, "What would you do if somebody was choking?" In addition, nursing staff we spoke with were not aware of what equipment was on site to be used if the need for cardio pulmonary resuscitation arose. They told us that they would use a bag to pump oxygen into the person's lungs but there was not one. They also told us that there were not any masks available at the service. However we found a face shield and a full face mask in the first aid kit in the nurses' station. Therefore we could not be confident that the correct action would be taken if these emergencies arose. This placed people at risk of not receiving appropriate care and treatment when required.

The issues highlighted above evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although systems were in place to safeguard people from abuse we found that these were not always robustly applied. In a quality monitoring report of 30 June 2015 we saw that the monitoring officer had written, "Should this person have raised their concerns with their care manager it would have instantly triggered a safeguarding alert. The issues raised would have been indefensible." However, a safeguarding alert was not raised and a formal investigation was not carried out. We were told by the monitoring officer that a safeguarding alert was not necessary as the matter was dealt with at the time and that it would have only been a safeguarding if the matter had not been addressed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

Staff were aware of the service's safeguarding policies and procedure in order to protect people from abuse. They were aware of different types of abuse. One member of staff told us, "There are different categories of abuse. I would suspect if there were bruises and marks on people or a behaviour change from what is normal." They knew what to do if they suspected or saw any signs of abuse or neglect. Staff told us that they had received safeguarding adults training and that they would report any concerns to senior staff. One member of staff told us about a situation when they had been concerned about a person and had reported this to the manager. Appropriate action had been taken to safeguard the person concerned.

Medicines were ordered, stored and administered by staff who had received medicines training and had been assessed as competent to do this. In the nursing unit medicines were administered by the nurses and by senior carers in the residential unit. We saw that staff administering medicines took time to encourage people to take their medicine and then signed the Medicines Administration Records (MAR) once it was done. We also heard a member of staff explaining to a person about their medicines. They said, "There's just one tablet to take and it's to help with your pain".

Some people were prescribed medicines to be administered once per week and there was evidence that the date these were next due was clearly documented on the MAR so that there was not a risk of missing a dose. For people prescribed the oral anticoagulant warfarin the dose recorded as given, correlated with the latest blood result and dose recorded in the person's anticoagulant record. Therefore people received the correct dosage. For other medicines we saw that the MAR included the name of the person receiving the medicine, the type of medicine and dosage, as well as the date and time of administration and the signature of the staff who administered it. We checked the controlled drugs and found that the amount stored tallied with the amount recorded in the controlled drugs register.

We found that risks were identified and systems put in place to minimise risk and to ensure that people were supported as safely as possible. People's files contained risk assessments relevant to their individual needs. For example, falls, malnourishment and the development of pressure ulcers. Individual risk assessments were reviewed by staff each month, or sooner of needed, to ensure that they were up to date.

The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were also maintained and checked to ensure that they were functioning appropriately and were safe to use. The records also confirmed that appropriate checks were carried out on hoists, pressure relieving mattresses and fire alarms to ensure that they were safe to use and in good working order. Systems were in place to ensure that equipment was safe to use and fit for purpose. A fire risk assessment was in place and staff were aware of the evacuation process and the procedure to follow in an emergency. People were cared for in a safe environment.

The provider's recruitment process ensured that staff were suitable to work with people who need support. This included prospective staff completing an application form and attending an interview. We looked at three staff files and found that the necessary checks had been carried out before staff began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with people who need support. Nurse's registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom.

During our inspection we found that there were sufficient staff on duty to meet people's needs. This was echoed by people who used the service and their relatives. One person said, "Plenty of staff." A relative said, "Always someone around. Never no-one in lounge." However staff felt it was very difficult at times particularly when they had to rely on agency staff, which was difficult when they had to wait for them to come in. When asked what were the challenges for the service one member of staff responded, "Staffing levels." We saw that during July, August and September 2015, ten new care staff had been appointed. This included health care assistants, nurses and a deputy manager. Additional domestic staff and an administrator had also been recruited. There had been a reliance on

Requires improvement

Is the service safe?

agency staff but this had decreased as the new staff had been recruited. This meant that more shifts were covered by permanent staff and that a more consistent service was provided.

We saw that all areas were clean. The laundry was well laid out with defined clean and dirty areas. The senior cleaner showed us the cleaning schedule, which they signed when the jobs were done. The cleaning trolley was well organised and buckets colour coded to ensure that they were used in the correct area and to minimise the risk of cross infection. There was no odour around the home, indicating a robust cleaning schedule. People were cared for in a clean and hygienic environment.

Good

Is the service effective?

Our findings

The service provided was effective. People who used the service and relatives praised staff who they felt knew what they were doing and how to support them. One person said, "Staff are okay to look after me." One relative told us, "Get the feeling staff are trained well. Feel I can leave [my relative] and not worry." Another said, "Staff know what to do and do it."

People were supported to access healthcare services. We saw that appropriate requests were made for input from specialists such as a speech and language therapist, dietitian and palliative care practitioners. People's healthcare needs were monitored and addressed to ensure that they remained as healthy as possible and the GP visited for a weekly 'surgery'. One visitor told us that their relative was looked after well when they had a chest infection. Another told us that when their relative had fallen, staff acted quickly and called the ambulance.

People's healthcare needs were met. One healthcare professional told us, "From a medical point of view they are getting good support." The other said, "It is fantastic and a wonderful improvement that [the patient's] pressure areas are so much better. This is due to the dedication of the staff and input from the tissue viability nurse." We saw that medical visit forms were completed each time a person was seen by a healthcare professional. This meant that there was a record of people's healthcare needs and any recommended action or treatment.

The provider had an in house trainer who was qualified to deliver basic training plus the theory and practical side of moving and handling and some of the more specialist nurse training. In July, August and September ten new care and nursing staff had been employed and the necessary training was being arranged for them. From talking to staff and checking the training records we found that staff who had been working at the service for a long period of time had received appropriate training. This included safeguarding, health and safety, Mental Capacity Act, Deprivation of Liberty Safeguards and moving and handling. A nurse told us that they had asked for training for phlebotomy (taking blood samples) and syringe driver training for end of life care. This had been agreed and the nurse was to attend the relevant courses when they are available. People were supported by staff who received appropriate training to enable them to provide an effective service that met their needs.

Staff were clear that people had the right to and should make their own choices and understood that people's ability to make choices could vary from day to day. They had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA is legislation to protect people who are unable to make decisions for themselves. One member of staff told us, "I've had training in MCA and it means the capacity of the resident to make decisions. Residents even with dementia will have some capacity."

The deputy manager was aware of how to obtain a best interests decision or when to make a referral to the supervisory body to obtain a Deprivation of Liberty Safeguard (DoLS). DoLS is where a person can be legally deprived of their liberty where it is deemed to be in their best interests or for their own safety. At the time of the visit, one person had DoLS in place and the deputy manager had discussed with their social worker the need for another person to have a DoLS. Systems were in place to ensure that people's human rights were protected and that they were not unlawfully deprived of their liberty.

Staff told us that the manager was approachable and supportive. One member of staff said, "I feel very supported. The management step in when we are busy." Systems were in place to share information with staff including handovers between shifts and staff meetings. Therefore people were cared for by staff who received support and guidance to enable them to meet their assessed needs.

People were provided with a choice of suitable nutritious food and drink. They told us they were happy with the quality of food and the choices available. One person said, "Lovely desserts." A relative told us that they had asked to try the food and had found that it tasted good and looked nice.

The chef had designed the menu by asking people what they wanted and liked and then including food that would support them to have a healthy balanced diet. The chef told us that the service was able to cater for a variety of dietary needs. At the time of the visit this included diabetic, vegetarian, soft and pureed diet. We found that the chef was aware of people's dietary needs and told us that to

Good

Is the service effective?

improve nutritional intake full fat milk and cream were used in their meals and desserts. The chef also made desserts suitable for people with diabetes. We saw that some people required a pureed diet and each food was pureed and served separately to enable them to enjoy the different tastes. Therefore people were supported to have meals that met their needs and preferences.

People were supported to eat and drink sufficient amounts to meet their needs. People said they got enough to eat and that they could have a drink when they wanted one. We saw that people were offered drinks throughout the day including lunchtime. Some people ate independently and others needed assistance from staff. We observed that staff appropriately supported and encouraged people to eat and that they were not hurried. When there were concerns about a person's weight or dietary intake we saw that advice was sought from the relevant healthcare professionals. One visitor told us that their relative had lost weight because of a health problem and that staff had been, "quick to notice" and arranged for supplements to, "build them up".

The service was provided in a large purpose built building in a residential area. It was newly built on the site of one of the provider's smaller homes which was then demolished. We saw that the environment was designed to meet the needs of the people who used the service and was accessible throughout for people with mobility difficulties. It was also designed to be 'dementia friendly'. The person responsible for the design and building of the service had attended a dementia design course and had used this knowledge when planning the new building. Adapted baths and showers were available on all floors and specialised equipment such as hoists were available and used when needed. People lived in an environment that was suitable for their needs.

Good

Is the service caring?

Our findings

People were positive about the care and support they received. Everyone we talked with spoke highly of the staff. They told us that staff were kind, caring and respectful. One relative said, "I am very happy with the care here. They are brilliant. [My relative] needs a lot of care and they get it." Comments from people who used the service included, "Very, very polite. Very, very nice. Always ready to help. Very caring" and "Staff answer my questions. No complaints about staff".

The two healthcare professionals we spoke with were also very complimentary about the caring way in which people were supported. One said, "Staff here are really helpful and kind. The patient I see is very happy." The other told us, "I would say this home is very caring. They have had a difficult time here but everything is settling down now."

People's privacy and dignity were maintained. Staff said they respected people's privacy and dignity by knocking on doors before entering rooms and when supporting them with personal care they ensured people were not too exposed and that doors and curtains were closed. People told us they could lock their bedroom door if they wished and confirmed that staff knocked before entering their room.

We observed that staff supported people in a kind and gentle manner and responded to them in a caring and respectful way. For example, one person became agitated whilst staff were transferring them to a wheelchair. The person became verbally abusive but staff took their time, they chatted to the person, calmed them down and then completed the transfer.

Although there had been new staff in post recently the staff we spoke with knew the people they cared for. They told us about people's personal preferences and interests and how they supported them. One relative said, "The staff are very friendly and helpful. They understand [my relative's] needs."

People were supported and encouraged to remain as independent as possible. One member of staff told us, "We encourage them to express what they want. We want them to keep making their own choices. We do chair exercises in the morning to keep them fit so they keep mobile for longer." Another said, "We try and keep them independent by encouraging them to move if they can rather than in a wheelchair." We saw staffing encouraging one person as they walked with their zimmer frame. The member of staff was with the person and reassured them and told them that they were doing well.

People's personal information was kept securely and their confidentiality and privacy was maintained. We saw that individual files were kept in the nurses' station, which was a small room next to the lounge area. Staff told us that they would never disclose people's personal information without permission.

People were supported by staff to make daily decisions about their care as far as possible. We saw that people made choices about what they did, where they spent their time and what they ate.

Staff provided caring support to people at the end of their life. From the notes of a person who had recently passed away we saw that the person had received excellent full nursing care, and was managed well in their last 24 hours. There had been regular input from the hospice crisis team, the GP and all the staff.

Requires improvement

Is the service responsive?

Our findings

People who used the service and their relatives were positive about the way the staff responded to their needs. One person said, "[My relative] has all she needs here and what she wants."

However, the service provided was not consistently responsive. Each person had an individual care plan which set out the care and support they needed. However, appropriate care plans were not always in place particularly for people who were using the service on a respite or short break basis. For example, one person's care plan indicated that they could be "aggressive." It also stated that the person was at high risk of hypoglycaemia (low blood sugar). However, the deputy manager told us that the person had never had a hypoglycaemic episode and was low risk. There was nothing in the person's file to indicate what their blood sugar levels should be. A hypoglycaemic attack could be mistaken for "aggressive behaviour". There was not any guidance for staff to follow and they did not know the person and therefore may not have responded appropriately to them. For another person we saw that the number of staff required to support them sometimes said one, then two and then back to one again. There was not any indication as to why these changes had been made. Some people had care plans in place with regard to their medicine and others did not. We saw that the deputy manager was in the process of auditing care plans to ensure that they contained the correct information and were up to date. The process of updating care plans had started but this had not been completed.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. A member of staff told us, "I can give a choice on food and clothing. Some residents definitely want to dress in a certain way." People told us that they could make choices about their care and support. They told us that they chose when to get up and when to go to bed. Also that it was their choice if they locked their bedroom door or left it open. We saw that people were consulted and staff asked their permission before doing things for them.

People's individual records showed that a pre-admission assessment had been carried out before they moved to the service. Information was also obtained from other professionals and relatives. The assessments indicated the person's needs and gave staff the initial information they needed to enable them to support people when they started to use the service.

Changes in people's care needs were communicated to staff during the handover between shifts. The interim manager had introduced written more structured handovers to ensure that staff received the up to date information they needed to carry out their duties and to respond to peoples current needs.

We saw that the service's complaints procedure was displayed on notice boards in communal areas around the service. Complaints were logged and actioned by the manager. We saw that in July a relative had raised issues of concern. These had been looked into and we saw the written response that had been sent to the person. Action was taken to address the issues. Relatives and 'resident' meetings were held and this also gave people an opportunity to give feedback about the service and any concerns they might have. People used a service where their concerns or complaints were listened to and addressed.

Although we could see that some activities and entertainment were arranged these were limited. There had recently been a garden party which the Mayor had attended and people said they enjoyed this. One person told us that they had arranged an entertainer and the service had provided cakes and decorations for their relative's birthday. We saw that one member of staff took a seated exercise class, which people seemed to enjoy. The provider had recognised that activities need to be developed and improved and an activity worker had been recruited and was just waiting for the necessary checks to be completed. The provider was also in the process of recruiting volunteers to spend time with people and to participate in activities with them. Therefore people's social activities should improve.

Requires improvement

Is the service well-led?

Our findings

The service had not been consistently well led and had not been robustly managed. This had been identified by the provider and action had been taken by them to address the issue. There was not a registered manager in post. The registered manager left in May 2015 and since then an experienced manager from another of the provider's services had been managing the service. At this inspection the provider informed us that the interim manager would be staying at Moreland House. However, at the time of writing this report the interim manager had not applied to cancel their registration at the other service and had not started the process to be the registered manager for Moreland House.

There were clear management and reporting structures. In addition to the interim manager a deputy manager had recently been appointed. People informed us that they were happy with the new management of the home and felt comfortable raising any concerns when they arose. One relative told us, "She [the interim manager] is on the ball. Another said, "[The interim manager] is fine. No complaints. Really happy that [my relative] is here." A third commented, "Well managed. More relaxed now"

Staff also spoke positively about the new management arrangements. A member of staff said, "The manager has an open door policy. I can see a change for the better once everything is in place." Another told us, "The management here is new and they are really good."

In December 2014, when building work had been completed, Moreland House changed its registration from a 20 bed home providing personal care and accommodation for older people to a 50 bed home providing nursing and personal care or older people. There had been a number of staff vacancies which had resulted in a high dependency on agency staff and people had not received consistent support from staff that they knew and who were fully aware of their needs. Recruitment was ongoing and several new staff had been recruited. The use of agency staff had decreased and regular agency workers were covering shifts when needed. The provider told us that they had not actively been advertising or trying to fill the places at the service as they wanted to ensure that sufficient staff were employed and trained and that the service was ready to support more people.

People were consulted about what happened in the service. They were asked for their opinions and ideas. During the planning and changes to the service the provider held meetings with people who used the service and their relatives. In addition he visited the service most weeks and was available to talk to people about any issues or concerns they might have. People were listened to and their views were taken into account when changes to the service were being considered and implemented.

We found that the interim manager and the deputy manager monitored the quality of the service provided which ensured that people received the care and support they needed and wanted. This was both informally and formally. Informal methods included direct and indirect observation and discussions with people who used the service, relatives and staff. Since the deputy manager had been in post more formal audits had been carried out. We saw from these audits that some of the issues found during the inspection had recently been identified and action was being taken to address them. For example, medicines training had been arranged, name badges had been ordered for staff and new care plans were being introduced. Therefore, people were provided with a service that was now satisfactorily monitored by the management team to ensure that it was safe and met their needs.

The provider had systems in place to monitor the quality of service provided. The manager was required to complete a monthly computerised quality report, completed audits, accident reports, complaints and other issues were recorded on a shared drive and senior managers of the organisation monitored these. Provider monitoring visits were carried out and a report written indicating what they had looked at and their findings. We saw that provider visits had taken place in January, April and June 2015. However, the reports did not always clearly indicate the action required or that actions from previous visits had been followed up. **We recommend that provider monitoring reports clearly indicate any action required along with timescales for completion. Also that subsequent visits check and report on the progress made to complete the actions**. This will make the monitoring process more robust and help to ensure that issues and concerns are dealt with in a timely fashion and are not overlooked.

The provider also sought feedback from people who used the service and stakeholders by means of an annual quality

Requires improvement

Is the service well-led?

assurance questionnaire. Responses from this were analysed and plans put in place to respond to any issues that had arisen. Therefore, people used a service which sought and valued their opinions which were listened to and acted on to improve and develop the service.

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 Systems were not in place to ensure that service users received safe care and treatment. They were not adequately protected from risks. This included the risk of not receiving their prescribed medicines safely and the risk from staff not being skilled and knowledgeable enough about some aspects of care. Regulation 12 (2) (c) & (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not adequately safeguarded from possible abuse. Systems and processes to prevent abuse and improper treatment and to investigate these were not effectively implemented. Regulation 13 (2) & (3)