Saffronland Homes

Nuffield Care Centre

Inspection report

Haigh Crescent
Redhill
Surrey
RH1 6RA

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12 July 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on the 12 July 2017. Nuffield Care Centre a care service with nursing operated by Saffronland Homes partnership. The service provides nursing care for up to 35 older people who may have a physical disability or be living with dementia. At the time of our inspection 24 people were living at the service.

This service was previously registered under a different legal entity and was last inspected on 31 May 2016 where the overall rating was Requires Improvement. This is the first inspection under the new legal entity. Despite the change in registration the provider and registered manager have remained the same.

There was a registered manager in post that supported us on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst people said they felt safe living in the service there were not always enough staff deployed to meet people's needs, particularly in the afternoon.. People sometimes had to wait to receive the care they required and told us that staffing levels were too low.

The requirements of the Mental Capacity Act 2005 (MCA) were not always followed correctly and not all staff understood their responsibilities under the MCA. People had applications made to deprive them of their liberty when they had capacity to make this decision.

Staff did not have up to date training in all key areas and supervisions were not always being completed by the registered manager. This meant that staff may not be aware of, or follow best practice.

The mealtime experience for people could be improved. Feedback we received was mixed with some people saying the food was not as good as it could be whilst others were happy with the quality of food provided.

People, relatives and staff told us that activities were limited and could be better. The activity co-ordinator had left recently and staff did not always have the time to spend with people to provide meaningful activities.

The provider did not have robust quality assurance processes in place. Quality assurance systems had failed to identify the issues seen on the day of the inspection. Some safety checks had not been completed and where an audit had been completed there was limited or no information about what steps had been taken to address areas of concern or set timescales for improvements. There were breaches in regulations that had not been met from the previous inspection.

Safe recruitment procedures were in place and staff had the required checks made before they started employment in the service. Staff knew about what should be referred as a safeguarding concern and were able to describe what constituted abuse. We identified one concern that had not been recognised as a safeguarding matter and asked for this to be referred to the local authority straight away.

Riske to people were identified to help keep them safe from avoidable harm. People had risks assessments in place that were up to date and relevant. Where people had specific health risks these had been identified and action taken to minimise the chance of avoidable harm. Medicines were administered when people needed them and recording of this was good. The storage and disposal of medicines was safe.

People were supported to attend healthcare appointments with other care professionals such as opticians, dentists and their GP.

People described staff as caring and kind. We saw staff engage positively with people on the day of the inspection. Relatives told us they could visit their loved on when they wished and had been involved in planning of care where appropriate.

Before people moved into the service they had an assessment of their needs to ensure care could be provided. Care plans were detailed and reviewed regularly to ensure staff had the most up to date picture of people's needs. There had been one complaint since the last inspection which had been responded to in line with the provider's complaint policy. People felt able to raise any concerns they may have with the registered manager.

The registered manager was described positively and staff felt supported by her. Notifications to the CQC had been submitted appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff deployed to meet people's needs, particularly in the afternoon. Safe staff recruitment procedures were in place.

Staff understood when to raise safeguarding concerns and referred them to the local authority appropriately.

Risks to people's health were known by staff and action taken to minimise avoidable harm.

People received their medicines when they needed. Medicines were stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The Mental Capacity Act was not always being followed and Deprivation of Liberty Safeguards applications were not always made correctly.

Staff did not always have adequate support and training was not completed.

There were mixed views about the food. Improvements could be made.

People had access to other care professionals to help maintain good health.

Is the service caring?

Good

People told us that staff were caring and kind. People's privacy was maintained.

People told us they, and those close to them were involved in the planning of their care.

People's relatives and friends were able to visit when they

wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us there could be more activities provided. Activities on the day of the inspection were limited.

People's needs were assessed when they entered the service and care plans reviewed regularly.

People were aware of how to voice their concerns or complaints about the care they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of robust auditing in place to monitor the quality of the service provided. There were breaches in regulations that had not been met from the previous inspection.

People told us the staff were friendly and supportive and management were always visible and approachable.

People described the registered manager as good and supportive. Staff told us they felt supported by the registered manager and felt comfortable reporting any concerns to them.

Nuffield Care Centre

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 12 July 2017 and was unannounced.

The inspection team consisted of three inspectors, one of whom had a nursing background 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 care service.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We also spoke to the local authority quality monitoring and safeguarding teams for their views on the service.

The provider had completed 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. This information was reviewed to see if we would need to focus on any particular areas at the service.
To find out about people's experience of living at the service we spoke with eight people, five relatives and six staff including the registered manager. We spent time observing staff and how they cared for people.

We reviewed care and other records within the service. These included five care plans and associated records, medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out. We also spoke to a visiting healthcare professional. We asked the registered manager to send us further evidence after the inspection in relation to staff training which they did.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff deployed to meet people's needs. There were mixed comments from people about the number of staff working which included "Sometimes they are short of staff", "At times they are short-staffed" and "Staff numbers could be better". One person who lived on the upper floor told us there was only one member of care staff on duty in the afternoon the previous day. Other people commented "Staff are here sometimes, not at other times" and "When I call, they come as soon as they can".

Staff also told us that they thought that there were not always enough of them to meet people's needs, particularly in the afternoon. One member of staff told us "It would be nice to have more staff in the afternoon" and "Sometimes everything runs smoothly and we work quickly, other times things happen and people have to wait a bit."

Staff were task oriented and did not have the time to spend with people other than to deliver basic care. We saw that people sometimes had to wait to get the care they needed. At 10.30 am one person wanted to get out of bed as they knew they had an appointment.. We heard them calling staff to help them. Staff acknowledged this and said they would be back to attend to them however half an hour later we had to ask the nurse to intervene. It still took a further 15 minutes before personal care was given. At that point the person told care staff they had soiled themselves. In the afternoon on the upper floor there was only one member of care staff on duty to look after 13 people as another member of staff was on their lunch break. We had to ask for an extra member of staff to be present to ensure people were kept safe.

The registered manager told us care staff undertook activities with people for two hours in the afternoon whilst a replacement activity co-ordinator was recruited. We observed that staff tried to engage people in a group activity in the afternoon however for those that were in their rooms there was limited or no interactions.

The service had 11 people living on the ground floor and 13 people on the first floor. The registered manager told us a dependency tool was used and the provider assessed what safe staffing levels were. This detailed what care hours should be based on peoples assessed needs. From a review of this there were not enough staff deployed to care as most people had high level needs based on the definition used in the dependency tool. In the morning there were two nurses on duty, one on each floor, and seven care staff, four on the ground floor and three on the first floor. In the afternoon there was one nurse and five care staff. At night there was one nurse and three care staff. Ancillary staff employed included a chef, kitchen assistant and domestic staff.

Staff were not deployed in a way that provided support to people when it was needed. This is is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. There was an up-to-date record of nurse's professional registration with the Nursing and Midwifery Council

(NMC). All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms were fully completed and any gaps in employment explained. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

People told us they felt safe. One told us they felt safe as there was "No trouble about security" whilst another said they felt safe as staff were "Very nice people". Staff had safeguarding training and were able to identify the different types of abuse. They knew how to refer concerns should they suspect abuse was taking place and were aware a referral to the local authority should be made. One staff member told us, "I don't think abuse would happen here but you have to know what to do if it does". Another told us "I would let the CQC know if I had to". Staff said the registered manager had an 'open door' policy and they felt able to share any concerns they may have in confidence.

Staff were aware how to minimise known risks to people which helped keep them safe from avoidable harm. One person was being 'barrier nursed' as they had an infection which could be spread to other people. A notice was on their bedroom door requesting visitors reported to staff before entering so they could be given personal protective equipment (PPE). This would then be disposed of safely after use. Staff used PPE correctly throughout the day. Staff were aware of risks to people with specific nursing needs. One person had a percutaneous endoscopic gastrostomy (PEG) in place. PEGs involve placement of a tube into the stomach where nutritional liquids and medicines can be given. Staff were knowledgeable about the management of this and had been trained in how to use this.

There were up to date risk assessments in place for those who may be at risk of falling or developing pressure sores. These were reviewed regularly. One person who was at risk of developing a pressure sore had been placed on an air mattress to reduce the likelihood of this which was regularly checked. Incidents and accidents were now being reviewed and action taken to address any regular patterns or trends that may be identified.

People told us they received their medicines when they needed. One person told us "I do get my medication when I expect it" whilst another said "I am given it and they watch me take it."

Medicines were stored and administered safely. Medicines management followed guidance from the Royal Pharmaceutical Society. Trollies were not left unattended when unlocked and medicines were not signed for until taken by the person. There were no gaps in people's medicines administration records (MAR). People living with diabetes who required their blood sugar levels monitored had this completed by the nurses. Assessment tools were used to measure people's pain levels and to gauge the appropriate level of pain relief when needed.

Nurses were clear about the importance of safe medicines management. Medicines were acquired, dispensed and disposed of appropriately. During the medicines round we observed these were dispensed appropriately. Medicines were labelled with directions for use and contained the date of opening and expiry date. Creams, dressings and lotions were labelled correctly, signed for on topical MAR charts when administered and safely stored. Other medicines were stored in locked cupboards. Medicines requiring refrigeration were stored in a lockable fridge which checked regularly to ensure the temperature was correct.

Medicines given on an 'as needed' basis (PRN) were managed in a safe and effective way. PRN protocols were in place which outlined how, when and why they should be taken. Staff received regular training and had competency checks undertaken to ensure they kept up to date with best practice. The provider

undertook monthly audits in all areas of medicines management and issues identified as a result were acted upon in a timely manner. A yearly medicines audit had recently been completed by the dispensing pharmacist. No concerns were identified.

Requires Improvement

Is the service effective?

Our findings

We found there was not a clear understanding or consistent approach to how the Mental Capacity Act 2005 (MCA) was applied. The 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 services 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.

Staff were able to describe the basic principles of consent and the MCA and had recent training in this area. One told us "It's about when someone is able to do their own decisions of what they want. Some people have full capacity and tell us what they want to wear, or eat, or what they want us to do" and "If they don't have capacity the care plan says what we can do and I know the family have to be involved." We saw staff offer choices and respect people's wishes when carrying out their work.

Despite this we found that the MCA was not always applied correctly when depriving people of their liberty. Two people had capacity but there had still been DoLS applications made to the local authority by the registered manager. Some families were making decisions on people's behalf despite not having the legal authority to do so. Another person had lost weight and was having difficulty drinking. Advice had been sought from the GP and medicines prescribed for an infection. The person had recovered from their illness but their family requested their medicines continued. Nursing staff told us they "Don't do anything the family don't agree to". This demonstrates a lack of understanding of the principles of the MCA.

Failure to act in accordance with the MCA is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought that "Staff seem well trained" but were sometimes "Hurried" in their work. Staff told us they had "Done lots of training here." Nursing staff told us they received appropriate training to help them do their job. One told us "I've had the opportunity to do venepuncture and catheterisation updates whilst I've been here." One relative told us they had concerns about how their family member's catheter care had been provided and had questioned whether staff knew enough about this aspect of care. We asked the registered manager to speak to them about this to reassure them that staff would be reminded about this, which she did.

There was a training schedule in place which detailed what mandatory training staff were expected to complete. This included training in infection control, fire safety, safeguarding and manual handling. There

were gaps in the training records provided for established staff. For new staff training had not been completed in a large number of areas such as dementia awareness, Mental Capacity Act training, infection control, health and safety, fire safety and safeguarding. This meant staff would not have the most up to date information in these subjects. For clinical staff training was available we requested the information about this from the registered manager but this has not been provided.

The registered manager undertook group supervisions with the clinical staff and then clinical staff were expected to complete these for care staff. She also told us that appraisals and supervisions (one to ones) with staff were not fully up to date. The provider's policy in respect of this was there should be 'A minimum of six formal supervisions a year which are documented on a supervision form'. Staff told us they had regular supervisions (one to none meetings) so they could speak about any development needs and used the meeting as an opportunity to look at their individual performance but this was not happening in line with the providers own policy and was not always being recorded.

Despite the lack of regular, recorded supervisions some staff said they felt supported by the registered manager and could speak to her anytime. One told us "I do feel quite supported day to day".. One member of staff told us "I didn't really get an induction, not a formal one. I was shown around and worked with someone for a short while." Other staff received or were undertaking an induction.

Failure to provide staff with the required training and appropriate supervision is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was helping clinical staff with NMC nursing revalidation. Clinical supervisions were carried out by the registered manager. One member of nursing staff had requested wound care training and this was provided after contacting the Clinical Commissioning Group (CCG).

There was a mixed response about the quality of meals provided which is an area for improvement. One person commented that the food was "Not too good" whilst another said there was "No imagination" in relation to what was provided. Other people had a different view and spoke positively about their meals. One person said meals were "Reasonable" and another said food was "Quite good." Staff told us they tried to make the mealtime experience a pleasant one for people. One staff member said "If a resident doesn't fancy what they ordered, they can have the other dish or something else. Chef always does more than ordered."

Lunch was in the main dining area on the ground floor for eight people was supported by three staff. Other people chose to have their meals in their rooms. People chose what they ate the previous day and if they changed their mind could have an alternative if they wished. We saw this happen on the day. Where people needed assistance to help eat staff provided this and offered encouragement to others. People were heard saying they enjoyed the meal. The chef told us he monitored what people had eaten and would speak to the registered manager if he had concerns they were not eating enough. He also said that people were reliant on staff encouraging them and that "Maybe sometimes they are too busy for this." The menu had been changed three times following feedback from people.

There was an allergies and preferences list which the chef referred to so he could ensure meals were appropriate. Most information was correct about dietary type or need such as a diabetic diet. One person did not like fish however had been given this for lunch. We raised this with the registered manager to address. People who needed to be were weighed regularly to monitor any weight loss and where necessary action was taken to address this in most cases. One person had lost weight and was not drinking enough, staff had sought medical advice but no further action had been taken to address this. We asked the

registered manager to follow this up as soon as possible.

People's health care needs were being met. People told us they had access to healthcare professionals such as GPs, opticians and chiropodists. One person told us "The doctor does visit sometimes" another said "They would call the doctor if needed." The provider involved a range of external health and social care professionals in the care of people, such as dieticians, speech and language therapists and podiatrists. Advice and guidance given by these professionals was followed.

Good

Is the service caring?

Our findings

People were mostly positive about the caring nature of staff. One person told us "The staff are no trouble at all, they are quite friendly" Another person told us the nursing staff were "Brilliant" whilst another said "The carers are excellent".

We saw plenty of positive interactions between staff and people throughout the day. Staff told us they enjoyed building relationships with people. One told us "I love it working here. I'm growing to really like and know the people; I like to treat them how I would like my nan or grandad to be treated." One relative told us "They do treat X with respect".

We observed care and support given to people at lunchtime. There was a high level of engagement between staff and people, one person needed staff to help them eat their meal and this was given. Staff helped and the right pace and did not rush them whilst taking time to talk and encourage them at the same time. Peoples preferred names were used when staff spoke to them and were heard talking affectionately to them. People were supported to do things at their own pace and the atmosphere was calm throughout the day of the inspection.

Staff took steps to ensure people's privacy and dignity were met. People's rooms had a green light above their doors which was illuminated when personal care was being given and meant staff would not go into the room unexpectedly.

Throughout the day we saw staff knock on people's doors and wait for people's permission before entering. One person told us "Staff always knock before coming in, even if I've called them." We saw a member of domestic staff took time to speak to the person whose room she was cleaning and have a conversation with them about how their day was going. One member of staff noticed that a person's skirt had risen up and immediately went and straightened this so that their dignity was preserved. The importance of dignity was discussed at staff meetings to ensure that this was always considered.

People told us they were involved in their care although this was not always formally documented. The registered manager had introduced a poster called 'About me' which was a document kept in people's rooms to help give an overview of what their needs and likes and dislikes were. People said they liked this new document and had been involved in their completion. One person said that their relative deals with their care on their behalf whilst another said "They involve me in aspects of my care." One relative told us "They do involve my family in Mum's care". Relatives were encouraged to be involved and could visit the service when they wished to as visiting times were unrestricted. We saw one person had their family with them and helped them at lunchtime to eat.

People told us they were encouraged to be as independent as they wished. One told us "I do feel I am encouraged to as independent as I can be" and "I do feel I have independence and they give me choice." Bedrooms were decorated as people wished them to be and people were able to bring their own furniture and belongings when they moved in to make their rooms more 'homely'. One person who had a love of

reading took pleasure in showing us the collection of books they had.

Requires Improvement

Is the service responsive?

Our findings

People did not have access to meaningful activities. People and relatives told us that there was a lack of activities in place at the service and this is an area that required improvement. Comments from people and relatives were mixed. One person told us "There are no activities going on", another told us "There is not much entertainment, could do better."". A relative told us "There is music occasionally and residents enjoy that".

The registered manager told us the activities co-ordinator had recently left and care staff were expected to provide activities to people in the afternoon whilst a replacement was recruited. Most people spent time either in the lounge watching television or in their rooms. Staff tried to engage people in activities but did not have the time to do so in a structured way as they were mainly focused on providing care. There was a future activities timetable displayed which we were told by the provider would continue to be provided by care staff until a replacement had been recruited. For people in their rooms there was no opportunity to spend time with staff. One person was at risk of social isolation, their care plan recorded "'X enjoys chatting with care staff so please spend time with X to get to know them'. We did not see this happen on the day of the inspection. Staff told us they tried to make time to chat with people but said that activities were not often done with people.

There was a lack of meaningful activities in place for people. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives expressed concern about accuracy of their family members care plan as some detail was missing from it that related to how they should be supported to eat and drink. We spoke to the registered manager to ask them to address this. Pre-admission assessments were completed before people moved into the service to help ensure they could meet their needs. The care plans we saw were person centred with details of people's choices and preferences which were consistently documented and contained meaningful information about their social and personal histories.

Where people had particular healthcare needs a care plan was in place to guide staff on what they should do. One person was diabetic. Their diabetes care plan was detailed, relevant and up to date. There were clear instructions for when blood sugar levels should be taken and recorded day to day. There were protocols in place to manage potentially life-threatening fluctuations in their blood sugar levels. There was a description of potential causes and signs and symptoms of low and high blood sugar levels with guidance for staff on what they should do if this happened.

The service used a nurse summary sheet which gave relevant information to staff about people's needs and risks. This was regularly updated to ensure the information on it was current. Most people told us that staff were responsive to their needs and they received the care they needed and expected. One person told us they had felt unwell recently and staff had noticed this and taken action quickly to address this.

People and those that mattered to them were aware of how and who they could complain to if they had a

concern about any aspect of the care provided.

All staff were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures, which were on display in communal areas. The procedure clearly detailed who could be contacted in the event a complaint was identified with contact details of other organisations should the person be dissatisfied with the response. There had been one formal complaint since the last inspection which had been dealt with and responded to in line with the policy.

There had also been four compliments received where relatives for those that were cared for expressed their thanks for the care given. The registered manager told us she operated an 'open door' policy and encouraged people and relatives to speak to her if they wished to discuss any aspect of the care provided at the service.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they thought the service was well run but could be further improved. The registered manager was well regarded and people told us she was "Very nice". The registered manager was seen walking through the service on the day of the inspection and knew people well. Despite these positive comments there were areas that required improvement. Whilst there had been improvements in the monitoring of accidents and incidents there were areas that had not improved since the last inspection.

Staffing deployment needed to be addressed as people were sometimes waiting for care to be delivered, the application of the Mental Capacity Act was still not being consistently applied, and the lack of activities remained. In addition staff training and supervision had not always been completed. The provider information return completed by the registered manager stated these were taking place.

Whilst audits were being completed by the registered manager and senior managers these had not recognised the concerns we had identified. There had been an audit completed in April 2017 that focused on the improvements needed since the last inspection. Whilst this covered all areas of the service there was limited or no information about what steps had been taken to address areas of concern.

For example the audit had identified 'Staffing levels were high of the amount of clients' which contradicts feedback from people, relatives and our findings from this inspection. The section of the audit that related to people's involvement in planning their care recorded that care planning 'Needs developing but some efforts had been made'. The required action was recorded as 'As the nursing team become more involved in the care planning this will become easier'. It was not recorded how this would be achieved or set timescales for completion. The audit also identified that the registered manager 'Requires support to drive the change' but did not detail how this would be done.

There were other regular audits completed on the environment including fire safety and infection control, medicines and other aspects of the care provided. Fire safety checks should have been completed weekly however the last recorded audit completed by the registered manager was on the 13 June 2017.

During the inspection it was identified that one person with capacity wanted to go back to their home but was not being allowed to do so. The registered manager had taken some steps to try to resolve this by contacting the local authority however they had not recognised that the person was free to leave if they wished. We asked for this to be referred to the local authority safeguarding team to address as a matter of urgency.

We asked the registered manager for information after the inspection not all of which was received. This related to incidents that had occurred in the service that we had identified, such as the referral of a safeguarding matter and staff training not being up to date. There had been previous breaches in regulations that had not been addressed.

Failure to have an effective quality assurance system in place in order to monitor and improve the service

and a failure to provide information is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a business continuity plan in place which covered events that may affect the smooth running of the service such as extreme weather, sickness or power failure. This detailed the actions to be taken to ensure people were kept safe. There was also a clear flowchart of the actions required by the different departments within the provider to ensure peoples safety.

Staff told us "I feel supported by the manager. I have no concerns about working here" and "Its all good here, I'm enjoying it. The manager is nice and I feel I can go to her if I had any concerns." Staff meetings were held to discuss aspects of care including making sure staff used peoples preferred names, recording of care provided and consent. This was also an opportunity for staff to ask any questions or concerns they may have.

The registered manager told us that they had regular resident and relatives meetings to seek feedback on the care being provided. The last meeting had discussed the 'about me' posters that had been developed in people's rooms. This document recorded details about people that detailed what people's likes and dislikes were and gave information about them. People at the meeting said they liked this new document and had been involved in its completion.

At the residents meeting new staff were also discussed as well as the last CQC inspection report. Minutes recorded that people and relatives were aware of the current rating and felt their relatives were being cared for in a manner that they were happy with. At the previous meeting in March 2017 areas discussed included visiting times, how relatives could join their family members at mealtimes and what the menus would consist of, care planning and how they could contact the service if they needed to.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events to help monitor the quality of care provided.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have meaningful activities available to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act were not always being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust auditing in place

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed at the service to always meet people's needs.