Shaw Healthcare Limited

Warmere Court

Inspection report

Warmere Court
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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?	Good

Overall summary

The inspection took place on 2 June 2015 and was unannounced.

The home provided nursing care and accommodation for up to 40 older people including older people living with dementia. The home was purpose built and had two floors accommodating up to 20 people on each floor. Those people who required nursing care lived on the second floor and those who needed personal care on the ground floor. At the time of the inspection 37 people lived at the home. Each person had their own bedroom with an en- suite bathroom. Communal areas consisted of lounge areas, dining rooms and rooms where people could meet others. There was a garden which people could use. A day centre for up to eight people was run in one area of the home and residents were able to attend. This facility is not registered with the Commission and therefore did not form part of this inspection. The home

Summary of findings

had a staff team of four registered nurses and 29 care staff plus staff for catering and domestic duties. A further two registered nurses had started work at the home and were undergoing their induction.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff did not always provide care which was safe. We saw some examples where staff did not use wheelchairs in a safe way. Risks to people's health and well-being were not consistently assessed or planned for. People said they felt safe at the home and relatives also said people were safe at the home. Health and social care professionals said they considered the staff provided safe care.

Care needs were reassessed and updated on a regular basis, although we noted care records were incomplete. Omissions in people's care records meant they could not demonstrate how care was being provided as set out in care plans. Care plans included details about how people liked to be helped as well as cultural preferences. Staff were observed to respond to people's requests for support, but this was not always the case. This included staff failing to respond to someone's requests and a visiting professional who said staff did not always respond in a timely way when people asked for assistance by using their call points in their rooms.

Staff were trained in safeguarding adults procedures and knew how to report any concerns.

Sufficient numbers of staff were provided to meet people's needs. Pre-employment checks were made on newly appointed staff so that only people who were suitable to provide care were employed.

People's medicines were safely managed. Staff were trained and assessed as being competent to handle and administer medicines.

People told us they were supported by staff who were well trained and competent. Staff had access to a range of relevant training courses and said they were supported in their work.

People were supported to eat and drink and to have a balanced diet. There was a choice of food and people said they liked the food. Special dietary needs were catered for and nutritional assessments carried out when this was needed so people received appropriate support.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff and the registered manager were aware of the principles and guidance associated with the MCA although one staff member was not. Five of the total staff team had attended training in the Mental Capacity Act 2005 and the registered manager had planned additional training for staff.

People's health care needs were assessed and recorded. Care records showed people's physical health care needs were monitored and that people had regular health care checks.

Staff treated people with kindness and had positive working relationships with people. Staff were observed to ask people how they wanted to be supported. People and relatives described the staff as caring and helpful.

A range of activities were provided for people and the service had a staff team member employed as an activities coordinator.

The complaints procedure was displayed and people said they knew what to do if they were dissatisfied with the service they received. A record was made of any complaints along with details of how the issue was looked into and resolved.

The registered manager promoted an open and person centred culture. This included people and relatives being encouraged to express their views about the service and the provider responding to any issues raised. There were examples of the registered manager acting to improve the standard of care as a result of dealing with concerns or complaints. Staff were supported by the home's management who in turn monitored staff performance and values. A number of audit tools were used to check on the effectiveness of care plans, medicines procedures, the environment, catering and cleanliness. These were carried out by the registered manager and by the provider.

Summary of findings

We found two 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 this 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 

The service was not always safe. Staff did not always safely support people, particularly in the use of wheelchairs. Care plans did not always detail the support people needed to prevent injury.

Staff knew how to recognise, respond and report any suspected abuse of people.

People were supported by sufficient numbers of staff.

Checks were made that newly appointed staff were suitable to work with people in a care setting.

Medicines were handled and administered safely and staff were trained to support people with them.

Is the service effective?

Good 

The service was effective.

Staff were trained so they had the skills to provide effective care.

Staff were trained in the Mental Capacity Act 2005 and the majority of staff were aware of the correct procedures to follow if people did not have capacity to consent to their care and treatment.

People were supported to have a balanced and nutritious diet and the staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good 

The service was caring.

Staff listened and acted on what people said.

Staff generally treated people with warmth and kindness. They showed a commitment to caring for people and ensuring people were treated well.

People's privacy was promoted and people's cultural needs acknowledged in making arrangements for care.

Is the service responsive?

Requires improvement 

The service was not always responsive. Staff did not always respond to people in a timely way. This included delays in the serving of lunch. Some people and a health care professional said staff did not always promptly when people asked for help. Care was not always responsive to people's needs and preferences.

People felt able to raise any issues with the provider which they said were acted on.

Summary of findings

There was an effective complaints procedure which people, and their relatives, were aware of. Complaints were investigated and responded to.

Is the service well-led?

Good

The service was well-led.

The management of the home promoted a culture of openness with good communication with people, relatives and health care professionals.

The provider encouraged people and their relatives to express their views about the service and acted on concerns and complaints to improve the service.

There were systems of audit and checks on the standard of care, the environment and medicines.

Warmere Court

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 June 2015 and was unannounced.

The inspection team consisted of an inspector, a pharmacy inspector, a specialist advisor in nursing care and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider 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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

Some people who used the service were unable to verbally share their experiences of life at Warmere Court because of their complex needs. We therefore spent time observing the care and support they received in shared areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with 13 people and to two relatives of people. We also spoke with four staff and the registered manager.

We looked at the care plans and associated records for 11 people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with two community nurses who supported people in the home with health care needs. These people gave us their permission to include their comments in this report.

The service was previously inspected on 9 April 2013 and was found to be meeting our standards.

Requires improvement

Is the service safe?

Our findings

Staff were trained in moving and handling but did not always move people safely. Care plans included guidance for staff to follow regarding transferring people, which included the numbers of staff and equipment needed. However, we observed three people were moved in wheelchairs without footplates which placed people at risk of injury. The registered manager confirmed that for one of these people the footplates had been removed from the wheelchair when it was assessed the footplate should be in use. For another person there was a record in the care plans to say the footplates should not be used due to the person having difficulty bending their legs, which meant the service was taking the correct action according to this person's assessment. The omission of using footplates when moving people by wheelchair when those people were assessed as needing footplates placed people at risk of injury.

Risks were not consistently assessed or planned for. Some risk assessments were carried out and recorded with guidance for staff to follow such as for the use of bed rails to prevent injury to people, the prevention of falls and for mobility needs. Records showed referrals were made to community health and social care professionals for guidance and assessment of how to manage falls. However, for one person we noted the risk assessment form where bed rails were used had not been completed so it was not clear what the risks were or if the use of bed rails was safe. Another person who was assessed as being at risk of falls was strapped into their wheelchair when it was stationary. We spoke to the registered manager and one of the registered nurses about this and there was a lack of clarity as to why the person was strapped into the wheelchair for periods of time when it was stationary. This was not recorded in the person's care plan nor was there any risk assessment for the use of the wheelchair by the person when it was stationary. This was heightened by the fact the person was assessed as being a high risk of developing pressure areas on their skin. There was no record the person had agreed to the procedure. Therefore the person may have been at risk of injury or skin breakdown as a result of using the wheelchair in this way.

People's risks of developing skin pressure injuries were assessed using an assessment tool called a Waterlow score. Specialist equipment was available to relieve the risks of pressure areas developing such as pressure relieving mattresses. One person had developed a skin pressure injury but there was no care plan of how this should be dealt which meant staff did not have guidance to prevent the person developing skin pressure injuries. At the time of the inspection the lack of the care plan was identified by a registered nurse who had completed an incident form so the registered manager and staff could look into the matter. Care records were made regarding support to people for pressure area care. However, for one person there were omissions in this so it was not possible to tell if the person received care as set out in the care plan to prevent pressure injuries.

The provider had not always assessed the risks to the health and safety of people receiving care or treatment and had not carried out what was reasonably practicable to mitigate such risks. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home, that staff were approachable and they felt it was easy to raise any concerns they might have about their safety. People, relatives and a health care professional we spoke with gave mixed views about whether there were enough staff to safely meet people's needs. One professional thought the home needed more staff as the call bells were not always promptly answered when people activated them to ask for help. A health care professional said staff provided safe care to people.

Each floor of the home had its own staff team. On the ground floor, where up to 20 people with personal care needs lived, three care staff and one team leader were on duty from 8am to 8pm each day. At night time there was one support worker and one team leader. On the second floor, where up to 20 people with nursing needs lived, one registered nurse and four support workers were on duty. At night time there was one registered nurse and two support workers. The registered manager's working hours were in addition to this and catering, laundry, cleaning and maintenance staff were also employed. Staff said they considered there were enough staff on duty to meet people's needs, although one staff member said there were occasions when there were not enough such as in the mornings when the home was fully occupied. We observed there were enough staff to meet people's needs. This included there being sufficient staff to meet people's needs

Requires improvement

Is the service safe?

during lunch time. The registered manager said staffing levels were assessed and reviewed and could be increased if people's needs changed. Staffing was organised on a staff duty roster which showed staffing was provided at the planned levels.

The home had a shortage of registered nurses and was using agency nurses to cover for vacancies. At the time of the inspection two registered nurses were completing their induction and further recruitment of nurses was ongoing so the home would be fully staffed.

Pre-employment checks were carried out on newly appointed staff and staff were interviewed to check their suitability for care work. Staff confirmed their recruitment included reference checks and an interview. Application forms were completed by staff and these included an employment history for the staff member. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. The DBS maintains records of any criminal convictions or where staff are not suitable to work in a care setting. The provider also checked that any nurses were registered with the Nursing and Midwifery Council (NMC) as fit to practice. The service had taken action using formal disciplinary procedures where the safety of people was affected. Appropriate referrals of individual nurses to the NMC were made when this was needed.

Staff had attended training in safeguarding procedures and knew what to do if they had any concerns regarding neglect or possible abuse of people. There were safeguarding policies and procedures in the home so staff had guidance on how to report any incidents or concerns to the local safeguarding team. There was a notice in the home to make staff, relatives and people aware of the procedures for reporting any abuse.

Staff were trained in health and safety and in the procedures for emergencies. Each person's care records included guidance for staff to follow to safely evacuate people from the home in an emergency.

People's medicines were safely handled and administered. There was a system for ordering and administering medicines which included records made by staff when medicines when medicines were handled. People said they received their medicines as prescribed and there were records to show staff administered medicines to people correctly. Checks and records were made by staff on medicines being ordered and coming into the home and for medicines no longer needed. Staff received training in medicines procedures which included at least three assessments of their competency to safely handle and administer medicines. Regular audit checks were made on medicines stocks and records of medicines administered to people. Medicines were securely stored and this was also checked as part of the medicines audits. Where any errors were identified in the handling of medicines action was taken to reduce the likelihood of this reoccurring.

Care plans contained information so staff had guidance to manage people's treatment needs. Individual directions for medicines to be administered on an 'as required' basis were completed for some medicines but not all. The clinical lead explained that some people were able to verbally communicate their need for these medicines, which staff followed. **We recommend the provider use relevant legislation and best practice guidance to ensure the safe and consistent administration of 'as required' medicines for people.**

Good

Is the service effective?

Our findings

People told us they were supported by staff who were skilled and competent and that they had confidence in the abilities of the staff. People said they were supported with their health care needs and that staff arranged health care checks when this was needed. For example, one person said, "I'm diabetic so they check my sugar count and sort my food for me and take me to Worthing Hospital for my appointments." People said they liked the food and we saw there was a choice of meals for people.

Newly appointed staff received an induction to prepare them for their job. This was based on nationally recognised standards as well as a four day induction by the provider. The induction involved a period where staff worked in a supernumerary capacity so they could observe more experienced staff working with people. At the time of the inspection one staff member was undergoing their induction where they worked alongside staff as an additional staff member to those on the duty roster. Staff confirmed they received an induction which prepared them for their role.

Staff said they had access to a range of training courses such as medicines procedures, first aid, moving and handling and equality and diversity as well as qualifications in care such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. The provider informed us that more than 40% of care staff were qualified at NVQ level 2 or 3 in care and that three staff were presently studying NVQ at levels 2 and 3.

The registered manager maintained a spreadsheet record to monitor staff had attended training which was considered essential for their role. This included induction training, fire safety, health and safety, moving and handling and infection control.

Staff confirmed they felt supported in their role and received supervision. Staff appraisals were carried out. Supervision and appraisals of staff were organised well and recorded. A monitoring spreadsheet was used by the home's management team to check staff received regular supervision and appraisals and so any omissions could be addressed. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

The service had policies and procedures regarding the Mental Capacity 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These gave clear guidance for staff in assessing those who did not have capacity to consent to their care and treatment and for making decisions on behalf of those people, which are called best interests decisions. Care records showed people's capacity to consent to care and treatment was considered by the use of a Mental Capacity Act 'checklist.' There were procedures for making applications to the local authority where someone who lacked capacity to consent had their liberty restricted for their own safety. This is called a Deprivation of Liberty Safeguards (DoLS) authorisation. The registered manager informed us she consulted the local authority about this and hade made DoLS applications where needed. Staff told us they had received training in the Mental Capacity Act 2005 and the registered manager said five staff had attended this and there were plans for further staff to do so. One senior staff member we spoke with did not know about the principles and guidance when people did not have capacity to consent to care and treatment. This staff member was of the view that relatives could agree and consent to people's care and treatment when people did not have capacity to do so. This staff member was keen to discuss and learn about the principles of the MCA and the registered manager informed us this staff member was recently recruited and would be receiving training in the MCA. Another staff member said they were aware of the principles of the MCA and sought consent from people before supporting them. Staff were observed to ask people who they wanted to be supported and checked with them if they were satisfied with the way they were being helped.

People's nutritional needs were assessed and care plans included any support people needed with eating and drinking. Where needed food and fluid intake was monitored and recorded. People's weight was monitored and we saw many people had gained weight since being at the home. Specialist diets were catered for and people were referred to the dietician or diabetic nurse where needed. Cultural preferences for food were catered for and this was recorded in people's care plans. There was a choice of food and people were asked in advance what they wanted to eat. One person said, "You get a genuine choice for all your meals and then you can see it on the menu blackboard too." We observed the serving of the midday meal in the ground floor and first floor dining

Good

Is the service effective?

rooms. Due to the unforeseen absence of the cook the meal was more than 30 minutes late. When it did arrive, staff served it promptly in the ground floor dining room but were delayed serving it on the first floor. This was due to a food probe thermometer not working and a lack of serving spoons. People were assisted by staff to eat where this was needed. Most people told us they liked the food and one person described it as "OK." The dining tables were attractively laid with table cloths and serviettes.

A community nurse told us the staff made appropriate referrals when people's health care needed assessing. We saw records when staff liaised with the tissue viability nurse regarding the management of skin pressure areas, records of people receiving input from health rehabilitation services as well as people having eye sight and dental checks. A health care professional said the staff worked well with them regarding health care needs. Any advice given by the community nursing team was said to be "followed to a T."

People's health care was monitored and records showed routine checks were made on blood pressure, pulse and body temperature. Records also showed the GP was contacted by staff when this was needed.

Good

Is the service caring?

Our findings

People gave positive feedback about the caring nature of staff. For example, one person said, "My iPod conked out yesterday and the manager on duty came and took a look and in three or four minutes it was all sorted out, it was perfect, they care a lot." Other comments about the attitude of the staff included, "They're very very nice and very friendly," and, "They're all wonderful I'm very happy here, they're great." Staff were observed treating people with kindness and warmth. People said they were able to make choices in their daily lives such as in the food they ate and how they spent their time. People said they were able to get up in the morning and go to bed in the evening when they wished. One person said they liked to get up early and how staff supported them with this. Another person said they could get up later in the day if they chose to do so.

People said they liked the friendly atmosphere in the home. For example, one person commented, "I get a comfy night's sleep here, it's nice and quiet at night but you only have to come out at three o'clock in the morning, as I sometimes do, and you can see staff about. You never feel alone."

People said staff knew their needs and preferences well. Care plans reflected how people wished to be supported as well as details about cultural and religious beliefs. This was incorporated into how people were supported and in their end of life care. Information for staff about specific religious and cultural customs were available in care records so staff could learn about how people preferred to live and what was important to them. Staff told us they used care plans and were committed to treating people as individuals. Staff demonstrated their approach to care was to promote a good standard of care, to treat people with respect and with dignity. Staff said they treated people as if they were a member of their own family.

Staff were observed interacting with people during the lunch time meal. People were supported well. Staff were patient with people and assisted them in a dignified and gentle manner. People were consulted about how they wanted to be helped. Staff communicated well with people by being courteous, smiling and having good eye contact. Conversations between staff and people were spontaneous, friendly and good humoured. Staff and residents shared jokes and chatted about a variety of subjects. Staff knew what individual people were interested in and talked to people about this. We did observe one exception to this where staff failed to respond to a person who was gesturing for assistance. Staff did respond to the person but this was after several minutes. Staff were observed at other times and interacted well with people. Staff knocked on bedroom doors before entering so people had privacy. We heard on person say to a care staff member who was supporting them, "You are so lovely and you look after me so well, thank you."

Care records showed people were generally consulted about their care. People were asked if they had any preference for male or female care staff to attend to them. Two people we spoke to raised areas of their care where they said they had not been consulted but the care records showed these discussions had in fact taken place. This suggested that these people may need to be consulted again on these agreements to their care.

Each person had their own room so were able to spend time in private. One person said they liked to stay in their room and listen to music and other people said they enjoyed their room. Bedrooms were personalised with people's belongings and ornaments so they reflected their interests and personality. People were able to have a key to their bedroom door for privacy and security and this was recorded in people's care plans.

Information was displayed for people and visitors to see in the entrance hall. This included the home's brochure, information about the adjoining day centre and the provision of advocacy services for people. A newsletter was produced and displayed in the hall for the months of April and May 2015. This had details of events and developments at the home.

Relatives told us they were able to visit the home whenever they wished and that staff were receptive to them. A health care professional said staff always had a welcoming attitude whenever they visited.

Requires improvement

Is the service responsive?

Our findings

People gave us mixed views about the responsiveness of the service to their needs. Some people told us staff responded promptly when they asked for assistance by using the call points in their rooms whereas others, including a relative we spoke with, gave examples of when there were delays in staff responding. For example, one person said call bells were answered promptly, "before you know it two staff are here." A health and social care professional said they had observed on occasions that staff did not respond promptly to people activating their call points and suggested this could be due to a lack of staff but we did not observe this to be the case at this inspection.

One person showed us their finger nails which were long and dirty and said they would have to ask for these to be attended to as staff had failed to notice and attend to them. A relative also said staff were sometimes slow to respond to people's care needs.

We observed staff were delayed in serving the midday meal when the food had arrived in the dining room on the first floor. The heated food trolley arrived but food was not immediately served due to staff having to obtain a probe thermometer so the food temperature was checked. A further delay occurred when staff had to obtain a serving spoon from the kitchen. Several staff were slow to respond to one person's gestures for assistance during the lunch meal. The person was calling out and waving their arm but staff failed to respond. Staff noticed the person calling but ignored the person. The person became visibly frustrated at staff failing to talk to them. After several minutes a staff member went to the person and talked to them. At other times staff were observed to be attentive to people and checked if people needed any help.

Monitoring records were used to record when people were supported such as for food and fluid intake, pressure area care and continence care. These were not always completed as set out in the care plan and included omissions in delivering pressure area care, continence care and where dressings needed to be changed. For example, two people's wound dressings had not been changed as directed in the care plan according to the records. One of the registered nurses stated this was because they had been on leave. For another person an incident form identified they had a pressure ulcer but no care plan had been completed, which meant there was no guidance for staff to follow to prevent pressure areas developing. We also saw monitoring records regarding the delivery of care for skin pressure areas and continence care were not always completed which we informed one of the registered nurses about.

The provider had not always provided care that was appropriate to meet people's needs and preferences and had not monitored that care was being provided as set out in care plans. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person's needs were assessed before they were admitted to the home. Needs assessments were comprehensive and included communication, breathing, nutrition, personal care and continence needs. Care plans were completed to give staff guidance on how these needs should be met. There was also a care plan called the 'Essential Lifestyle Profile,' which gave details about people's preferred routines such as how they liked to spend their time and night time routines. People's cultural and religious preferences were detailed to show these needs were incorporated into how people were supported. Care plans were evaluated and reviewed on a regular basis and included evidence that people were consulted about how they wished to be supported.

People's needs were assessed regarding their interests and activities. An activities care plan was created for each person. Records of activities attended by people were maintained. There was an activities coordinator employed for 19 hours per week which the registered manager said would be shortly increased to a full time position. There was a display of activities for the month of June 2015 which showed three events by visiting singers. We observed staff engaging people in a quiz game in the afternoon. The registered manager said people could use the adjoining day centre if they wished. The majority of people said they were satisfied with the level of activities provided.

People were able to raise any issues about the home at the residents' meetings. We saw there were minutes of these meetings. The registered manager told us it was difficult to engage people at these meetings and held specific meetings to discuss and communicate issues about the home. For example, a recent meeting was held to discuss maintenance and repairs taking place in the home. Monthly relatives' meetings took place where relatives could raise express their views about the home.

Requires improvement

Is the service responsive?

The provider's complaints procedure was displayed in the home and people said they knew what to do if there were not happy or had any concerns. There was system of logging any complaint made along with details of the service's investigation and findings. An acknowledgment letter was sent to the complainant saying the matter would be looked into and responded to in a given time scale.

Written responses were made to complainants with details of the findings of the investigation into their complaint. The provider took appropriate action as a result of investigating complaints such as referring the concern to the local authority safeguarding team. The registered manager confirmed how the findings of any complaint investigation were used to learn and improve the service.

Good

Is the service well-led?

Our findings

People considered the home was well- run home with a culture where people could raise any issues or concerns. The staff and management were said to be approachable and receptive to comments or concerns. One person told us, "I had a problem in my bathroom and I only mentioned it yesterday and it's being sorted out right now." Another person said the management of the home made sure staff knew that a good standard of care was required. People and their relatives had opportunities to express their views and to contribute to the planning of the service at the regular residents' and relatives' meetings.

The provider told us in the PIR that there is an 'open door' policy where people and relatives can raise any issues. We observed the office door at the entrance of the home where the registered manager and administrative staff sat was open throughout the time we were at the home. A relative was comfortable in walking into the office and striking up a conversation about his relative's progress and care. The registered manager was receptive and listened to the relative and communicated well. A health care professional also said the registered manager was approachable and that the staff worked collaboratively to meet people's needs.

The provider used survey questionnaires to ask people and their relatives what they thought of the service so that any concerns could be acted on or improvements made. The registered manager said specific meetings were held with people and relatives to communicate any issues such as a recent plan for building work to improve the pipework.

Communication within the staff and management team took place through regular staff meetings and daily meetings between staff to discuss people's care needs.

Staff said the registered manager encouraged them to express their views about the service and that these were listened to and acted on. Staff said the registered manager was approachable.

The home had a registered manager who was open to improving the service. She highlighted how investigations into complaints and incidents had resulted in the service recognising where it needed to improve and acting on this. Examples were given of how the service had improved its communication with relatives and in the provision of special diets following complaints investigations.

There was a management structure so staff had access to support and advice. This consisted of a deputy manager as well as team leaders and registered nurse team leaders on each of the two floors of the home.

The registered manager said staff were able to develop specialisms so that care practices could be developed in the home. One staff member had a specialism in moving and handling and three staff were dignity champions with a remit to promote choice, dignity and care of people. The provider carried out observations of staff working with people as part of its quality assurance called a Quality of Life audit. The registered manager said this had identified staff interactions with people could be improved so they were more person centred, and, that this was being addressed with the staff team. When we spoke to the registered manager about the observation of staff failing to respond to one person at lunch time she was aware of the need to address this with staff.

The registered manager carried out self- assessment audits every three months which included checks on medicines procedures, care plans, catering, health and safety and infection control. These included an action plan to address any areas of improvement. The provider also carried audits of the quality of people's life at the home which outlined areas for improvement.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided to people in a safe way. Risks to people were not always assessed and reasonable action taken to mitigate against those risks. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not always provided care to people that was appropriate, met their needs and preferences. The design of care did not always meet people's needs and preferences. Regulation 9 (1) (2) (3) (b)