

Farriess Court Limited

# Farriess Court

## Inspection report

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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?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

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

Farriess Court was previously inspected by the Care Quality Commission on 6 July 2017. We found two breaches of the regulations. We asked the provider to complete an action plan to show what they would do and by when to improve the premises to promote people's safety and to ensure effective governance of the service. The overall rating for the service was requires improvement. We found some improvements had been made, however further improvements are required.

This is the second time the service has been rated Requires Improvement.

People were exposed to potential risk as some radiators and other heating devices used to heat some rooms within the service were not covered to protect people from coming into contact with hot temperature surfaces.

People told us they felt safe at Farriess Court. Individual risk assessments identified potential risks to people. Staff were knowledgeable about keeping people safe, which included their awareness of safeguarding and the implementation of the personalised risk assessments. People were supported by staff that had been recruited and had checks undertaken to ensure they were suitable for their role. People's medicine was managed safely.

We found improvements could be made for the benefit of people living with dementia, memory loss or confusion by considering how the décor and signage within the service could be developed, to improve people's well-being consistent with good practice guidance. We have recommended that all staff undertake training in dementia awareness to enable them to better understand and support those living with dementia.

People's needs were assessed to ensure staff could provide the support required. People's needs were met by staff that had the skills to provide safe care and who were regularly supervised and had their competency assessed.

People's health care needs were monitored, and people worked in partnership with staff to monitor their health. People were supported to have maximum choice and control of their lives and staff supported them in the least restrict way possible; the policies and systems in the service supported this practice. People's dietary needs were met and people spoke positively about the food.

People spoke positively about the care and approach of staff towards them. Staff's knowledge and

awareness of people meant they had developed positive relationships. We observed positive interactions with people, with staff providing opportunities for people to take part in activities and by spending time engaging in conversation.

People's records were electronically stored and were used by staff to update people's records throughout the day, providing a clear audit trail of the care provided and staff's observations as to people's wellbeing. People's preferences about their care had been sought and recorded to ensure staff supported people consistent with their wishes and expectations.

People were confident in raising concerns, we found concerns and complaints had been investigated and any necessary actions taken. However, information about complaints and other key information such as advocacy services and safeguarding were not displayed where they could be easily accessed and clearly visible.

The provider had not addressed all the areas identified within the previous inspection report for improvement. A range of audits had been introduced to monitor the quality of the service, however these had not identified the potential risk to people of hot surface temperatures of radiators. The provider's oversight of the registered manager through formal supervision was not robust.

People's views about the service were regularly sought and their comments in the main positive. However, the results once analysed were not shared with people to provide them with information about the service and the provider's plans in response to their views. The provider displayed the rating awarded by the CQC following its previous inspection on the notice board at Farriess Court and on its website.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## 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 consistently safe.

Potential environmental risks had not been identified, which placed people at risk. Personalised risk assessments were in place and were adhered to by staff to promote people's safety and well-being.

People were safeguarded from abuse as robust systems and processes were in place, which were understood and adhered too by all staff.

A robust system of staff recruitment was in place to ensure people were supported by suitable staff and that there were sufficient staff to meet people's needs.

People's needs with regards to their medicine were identified within their care plans and medicine management systems were robust.

### Is the service effective?

**Good** 

The service was effective.

People's needs were assessed to ensure the service could meet their needs.

Improvements had been made to the environment to better meet people's personal care needs through the installation of a refitted assistive bathroom. The environment could be further developed with consideration to good practice guidance to better meet the needs of those living with dementia.

Staff supported people in the monitoring and promotion of their health, which included ensuring people had sufficient to eat and drink. People had regular access to health care professionals.

Staff were supported through on-going supervision and had their competency assessed. Staff accessed training relevant to the promotion of people's health and welfare. We made a recommendation for all staff to receive training in dementia awareness.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

### Is the service caring?

Good ●

The service was caring.

People, family members and visitors spoke positively of the care provided, which included the attitude and approach of staff.

We observed positive interactions between people and staff and saw a majority of people's choices and wishes were promoted and respected.

People's dignity and privacy was recognised and met by staff.

### Is the service responsive?

Good ●

The service was responsive.

People and family members worked with staff to develop their care plans to ensure they received the support and care they required.

People were supported to maintain contact with family and friends. People had the opportunity to take part in activities held within the service.

People were aware of how to raise a concern or make a complaint. Complaints and concerns were documented and investigated by the registered manager.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

Improvements to the system for monitoring the quality of the service had been made by the provider. However, the audits had failed to identify some areas of potential risk to people.

The provider had not actioned all the areas for improvement identified within the Care Quality Commissions previous inspection report.

People's views about the service were regularly sought through surveys, a majority of surveys reflected people's satisfaction with the service. However, the analysis of their views and actions the provider planned to take to address any comments were not shared.

Staff spoke positively of the support provided by the management team. People we spoke with told us the registered manager was approachable.

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

We inspected Farriess Court on the 18 December 2018 unannounced.

The inspection was carried out by an inspector, an inspection manager 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.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted Derby City Council, who commission services from the provider; and Derby City Healthwatch, an independent consumer champion for people who use health and social care services.

We spoke with eight people who used the service. We spoke with three family members and friends who were visiting on the day of our inspection visit.

We spoke with the registered manager, deputy manager, the cook, two members of care staff and the administration assistant.

We reviewed the care records of four people who used the service. We looked at two staff records, to evidence their recruitment, induction, on-going monitoring and training. We examined documents which

recorded how the provider monitored the quality of the service being provided.



# Is the service safe?

## Our findings

At the previous inspection of 6 July 2017, we found the registered person had not ensured potential risks to people were mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. At this inspection we found the provider had taken action to address the shortfalls identified at the previous inspection. Windows had undergone maintenance work and alterations to reduce the likelihood of people accidentally falling through them. The locks on bedroom doors had been replaced to ensure they could be opened in the event of an emergency.

At this inspection we identified potential risks to people. Radiators and heaters in some part of the service which included, the area referred to as 'the stables' and the new extension, were not covered. We also noted radiators in some bathrooms, toilet facilities and the smoking room were not covered. This meant, people were at risk of burning themselves if they came into contact with the hot surface. The registered manager informed us they had spoken with the provider as a result of our findings.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Potential risks had been identified and assessed and guidelines as to how staff were to reduce risk were detailed within risk assessments. For example, supporting people with their personal care. Where people required equipment, such as a walking frame this was detailed within their risk assessment and care plan. People who required a walking frame kept their frame close by to promote both their independence and safety. Where people required the use of a hoist, the person's records provided clear information as to how the equipment was to be used, specific to that person's individual needs. The risk assessment detailed the number of staff required to support the person safely.

People and their visitors told us they felt safe and why. One person said, "I don't get scared or frightened." A second person said, "I have a big room and I haven't felt scared or frightened." A third person said, "I'm not frightened of anyone here." A fourth person told us, "I'm not frightened at all. I know where the office is. I can talk because there is always someone (staff) around." A family member said, "I have never seen anything to concern me. My relative is safe and so are the things in their room."

The registered manager responded appropriately when areas of concern were brought to their attention to ensure people's safety and welfare was promoted. Notifications were submitted to the Care Quality Commission (CQC) about potential abuse and safeguarding referrals made to the local authority.

Staff had received safeguarding training and other training relating to safety. They understood what procedures should be taken if they suspected or witnessed abuse. This included contacting outside agencies such as the police, CQC and local authority safeguarding teams. A member of staff told us, "I'd have no hesitation in reporting any concerns to CQC or social services."

Records showed people had Personal Emergency Evacuation Plans (PEEPs) in place, these provided clear

information as to the level of support each person would require, should they need to evacuate the building in an emergency. The PEEPs were stored centrally and were easily accessible in the case of an emergency.

The registered manager kept under review the level of support people required, they told us staffing levels were determined based on the needs and number of people using the service. However, there was no record to support how people's dependency levels were determined. We spoke with the registered manager about using a tool to assist them, they told us they would consider this. The registered manager confirmed that the provider, when requested by them, increased staffing levels to meet people's needs.

We found there were sufficient staff to meet people's needs. We looked at the staff rota and found there were three staff on duty throughout the day and two on duty overnight.

People were safeguarded against the risk of being cared for by unsuitable staff through the provider's recruitment procedures. A check with the Disclosure and Barring Service (DBS) had been carried out to check on prospective staff who intend to work in care and support services. This helps employers to make safer recruitment decisions.

The registered manager, deputy manager or senior carers who had received training in the safe administration of medicine were responsible for the administration of people's medicine. Care staff did apply topical creams as and when required, for example following the delivery of personal care. We found (MARs) were signed when all medicines were administered. Medicine was stored appropriately, and the temperature of the storage facilities were checked and found to be within an acceptable range. Appropriate systems and facilities were available for the destroying and return of medicines which were not used.

People's care plans included information as to the medicine they were prescribed and any known allergies. The care plan included specific instructions around their medicine, for example one person's care plan stated one of their medicines was to be given on a specific time each day. People's care plans stated how the person took their medicine, one person's care plan said staff were to place the medicine in their hand and that the person would take two tablets at a time, with water. People accessing the service for respite care, signed a declaration detailing whether they wished to maintain responsibility for the administration of their medicine or whether they wanted their medicine to be managed by staff.

The provider employed staff who were responsible for cleaning Farriess Court. We found the service to be clean and tidy and people's comments supported this. A family member told us when asked for their views as to the cleanliness of the service said, "The home seems clean." A person using the service told us, "They (staff) keep it clean."

Infection control audits were undertaken and any shortfalls were noted and action taken. For example, it was noted a headboard of a bed required replacing, this had been actioned. There were a number of locations throughout the service, which provided staff with easy access to personal protective equipment (PPE), to reduce the risk of the spread of infection, such as gloves and aprons. Staff were seen wearing PPE, when providing personal care and support, which helped to minimise the spread of infection.

# Is the service effective?

## Our findings

People's needs were initially assessed by the funding authority, who shared their assessment with the registered manager. The registered manager upon receipt of the assessment reviewed the information to decide whether they could potentially meet the person's needs. The registered manager arranged to meet with the person and in some instances their representative, to carry out their own assessment and this was confirmed by those we spoke with. Assessments were used to determine the level of support and care people required and were used to develop care plans, providing information and guidance for staff as to how they were to support and care for people.

A person told us, "I've been here for 4 days so far. The staff are quite helpful but they keep getting my name wrong. I came here from hospital. The manager came to see me in hospital. I didn't look around (here) before I came. They asked me if I wanted too, but I said no because I was too poorly."

A family member shared with us how their relative came to move into Farriess Court. "They (staff) did an assessment when my relative was still in hospital. I liked it here because it had a good feeling about it. I liked the décor in the room when I first looked at it, I looked at 10 different care homes before choosing this one."

The environment was decorated to a good standard. Lounges and the dining room were homely and inviting and people's bedrooms were personalised, for example with photographs and ornaments. The bathroom on the ground floor had been refurbished, making it accessible to people with mobility difficulties as well as providing a pleasant environment. However, the smoking room was not well maintained. The room was dark with poor lighting, the pull cord for the light was dirty and the chairs had holes and burn marks from cigarettes. One person we spoke with told us they did not use the smoking room as it was 'smelly' and therefore preferred to smoke outside.

We found improvements could be made to the environment through the implementation of good practice guidance by supporting people who experience confusion, sight or memory loss or those living with dementia, through the use of colours, textures and signage. This would provide an environment which was easier to navigate and provide opportunities for people to interact more effectively within the environment in which they lived.

Staff underwent an induction programme, which began with training in a range of topics related to the health, safety and welfare of people. Training was in the form of the completion of booklets, which were sent off to an independent company for validation. Following the initial induction, new staff then worked alongside an experienced member of staff for two weeks. During this period, they were encouraged to read the providers policies and procedures and to read people's care plans. Staff we spoke with confirmed the induction process they had undergone. Staff were supervised and had their competence assessed in a range of areas, which included medicine administration and the delivery of personal care, which included the use of equipment such as a hoist.

Training records showed staff had received regular training and updates in topics related to people's health,

safety and welfare. Some staff had attained a vocational qualification in health and social care with other staff working towards attaining the qualification. A person we spoke with told us, "They (staff) are well trained and know what they are doing." And a family member told us, "They (staff) seem to know what they are doing."

However, only a small number of staff had received training in dementia awareness, which had taken place three or four years ago. Staff we spoke with were not confident in how they should support or care for people living with dementia. The Care Quality Commission (CQC) recommends staff undertake dementia awareness training to ensure they have the necessary skills and confidence to care for people living with dementia.

A person told us, "The food is good, better than the hospital (they laughed). I give the cook top marks." A second person said, "The food is fantastic, everything you could wish for that's good."

People's needs in relation to their food and drink were assessed. Where people were assessed at being at risk of malnutrition or dehydration a care plan had been developed to assist staff. In some instances, people had been prescribed food supplements. Speech and language therapists assessed people who were at risk of choking when eating and drinking and to reduce risk, where appropriate a soft diet was provided. We noted that the chef had a clear understanding of people's dietary needs with the appropriate meals being provided.

The dining room was decorated with seasonal bunting and Christmas songs were playing, we saw people singing and humming along to the tunes. The tables were set with serviettes and condiments. People were served their meals and we noted that people who had chosen alternatives to the menu were provided with their choice. People's portion sizes were individual to each of them.

The menu was hand written on to a white board, some of the writing was smudged making it difficult to read. People told us the cook each morning asked them to choose what they wanted to eat from the menu.

People confirmed they had access to health care professionals. One person said, "The optician comes here." A second person told us, "The GP comes here if you need them." A visiting health care professional told us they had no concerns about the quality of the care provided and that staff were proactive in contacting them with any concerns. They said staff followed through on their advice.

A doctor or advanced nurse practitioner from a local doctor's surgery routinely visited the service each week to respond to people's health care concerns. People's care plans showed staff had liaised with a range of health care professionals, which included referrals to speech and language therapists when people experienced difficulty with eating and drinking.

People's records provided information as to people's health and whether due to their health needs they required ongoing support from specialist health care professionals. For example, people with diabetes had routine appointments to monitor a range of issues which included chiropody and optometrist services.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. The registered manager had submitted an application to renew a person's DoLS, at the time of the inspection there were no DoLS in place for those using the service.

Staff we spoke with had an understanding of the MCA and DoLS. Staff spoke with authority and conviction on promoting people's rights and choices. This was evident in our observations, where we noted staff offered choices in all care interventions, which included asking people what they wanted to eat and whether they wished to take part in activities.

## Is the service caring?

### Our findings

We observed people being offered choices as to what they wished to do, which including what they wished to eat or drink, people were offered opportunities to take part in activities and whether they wished to remain within their room or sit in one of the lounges.

On the day of our inspection visit, one person had not slept well the previous night, the person chose to stay in bed and get up later in the morning, the person's decision was respected by staff. However, we found one person's wish, which was to go out for a walk was not supported by staff. We observed the person throughout the day wore their coat, when we spoke with them they showed us their bus pass and told us they wanted to go out for a walk. Staff told us the person had recently moved to the service for respite care and when at home enjoyed going out for walks. Staff did attempt to provide alternative activities; however, the person was focused on their wish to go out. We asked during the staff handover meeting whether they had considered supporting the person in going out for a walk, we were told "no" as it was raining. Staff did not say as to why a walk in the rain was inappropriate.

We observed examples of people's privacy and dignity being promoted. For example, when we went to speak with a person in their room, the member of staff knocked on the person's door and asked if they were happy to speak with us. They also ensured the person was appropriately clothed and covered before we entered their room.

People's views about their care were sought and were used to develop their care plans, which were regularly reviewed. People's preferences in relation to their care were detailed within their care plan, for example the frequency in which they wished to have a bath or shower, the preferences for the time they preferred to get up and go to bed. People's preferences were also included, for example one person's care plan detailed the style of clothing they wished to wear whilst another person's including information that it was important to the person that they wore their watch.

People spoke positively about the staff. One person told us, "They (staff) look after me in the way that I want." A second person said, "If anyone could do it (care) better than here I would like to meet them." A third person who was receiving respite care told us, "I came here for a short break; however I have the option to stay and that's what I want to do."

Family members and visitors spoke positively about the staff. They told us staff knew people well. A visitor said the persons bedroom was very nice and had been personalised with family photographs.

Throughout the inspection we observed many positive and caring interactions between people in residence and staff, which showed the caring and supportive approach of staff and the kind and caring relationships that had developed. For example, a person sitting in the dining room told a member of staff they were cold. The member of staff went to the person's room and brought two cardigans to the dining room, the staff member supported the person in deciding which they wished to wear.

## Is the service responsive?

### Our findings

People's care plans and other records detailing care were stored electronically. Staff updated people's records using a hand-held device. People's care plans included information provided by the person themselves or that of their family member. Information recorded, supported a person-centred approach to care. For example, providing information as to what clothes people preferred to wear, how they wished to take their medicine and whether they preferred to have a bath or shower. Information about their lives prior to moving into Farriess Court was detailed for example, information as to their family, work and social activities.

A visiting health care professional told us the care of people receiving end of life care was really good and well organised and that staff communicated well with family members. People's care plans, in some instances, detailed their wishes upon their death held within a funeral plan. For people who did not wish to be resuscitated, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms recorded their wishes, and had been signed by the appropriate health care professional and were kept at the front of the person's records. To support end of life care, 'anticipatory medicines' were prescribed and these medicines were in place should they be required to manage their symptoms and pain.

Organisations that provide publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS) which says services should identify record, flag, share and meet information and communication support needs of people with a disability, impairment or sensory loss. We found the service had considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with AIS. For example, people's assessments had identified any communication needs, for example if they required to wear glasses, or a hearing aid.

People with specific communication needs were catered for, which included for one person a 'communication passport', which had been developed by a speech and language therapist. We used this to speak with the person to seek their views about the service. They person told us, "I rate here as 8 out of 10." The person spoke about their hobby with us and about their collection of objects of interest to them, which they had displayed in cabinets in their room.

People spoke to us about how they spent their time. One person told us, "There are so many things to do here. We've been playing skittles earlier. It was funny because the ball kept going under people's chairs." A second person said, "I get fed up sometimes and then I colour in." A third person said, "I've never done colouring before, I'm enjoying it. I like to do word searches. I like it that the staff help me." Staff were seen asking people if they wished to join in making Christmas Cards, which a number of people chose to do.

Family members and visitors shared their views about the availability of activities within the service. A family member told us, "They could do with more activities. When music is being played in the lounge I can see that the whole mood improves." The registered manager told us the activity co-ordinator was on long term leave, which meant staff had the responsibility of providing activities and stimulation for people. Visitors told us, "We came one day, there was a lady with a guitar and they were all singing, it was lovely to see."

They've had Carol singing, sometimes they play skittles with a hoop. They do activities with cards, a range of crafts and play dominoes." The visitors also said a monthly religious service took place and a Chaplain visited twice a week.

We saw a number of people sat reading a book or newspaper, whilst others watched the television. A group of people took part in a game of skittles, whilst others were offered the opportunity to take part in making crafts, which they enjoyed.

People told us they had not raised any concerns or complaint but knew who they would speak with should the need arise. One person said, "I have no complaints." A second person said, "I'd see the manager if I needed to complain." A family member told us, "I think my relative is happy. The [registered manager] is approachable. I haven't needed to make a complaint."

The main entrance had a notice board, however information did not include the complaints policy and procedure. We found the complaints policy on the wall of the conservatory, however this room was cold and therefore not a room used throughout the year. This had the potential to restrict people's awareness and access to the complaints process. The Care Quality Commission (CQC) recommends the complaints policy and procedure is prominently displayed within the service so as to be accessible to those using the service and visitors.

The most recent complaint was dated 12 months ago, we found this and previous complaints and concerns had been investigated and any action taken recorded. For example, one person had raised concerns about their relatives walking frame. The action taken, was to ensure the person's walking frame was close by them always.



## Is the service well-led?

### Our findings

At the previous inspection of 6 July 2017, we found the registered person did not have effective systems established to ensure compliance with the regulations. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. At this inspection we found the provider had taken action, however further improvements were needed.

The provider had updated auditing systems to include audits on a range of topics and areas, which included the kitchen, hand hygiene, infection control and care plans. Audits were electronically stored with action plans generated in most instances. We noted actions had been taken as a result of audits, which included changes to how meals were served to ensure they were kept warm. However, we found shortfalls were not always identified. For example, the environmental risk assessment had not identified some radiators and other room heating appliances were not covered and therefore no action had been taken to reduce the risk.

We found the provider had not taken on board all the findings as detailed within the inspection report of July 2017. For example, the previous inspection report had recorded a lack of formal supervision of the registered manager by the provider. At this inspection the registered manager informed us they had had one supervision recently, however they confirmed there was no documentary evidence to support this or to evidence the issues discussed and any follow up actions required by either person.

People's views about the service were sought regularly through surveys. Surveys we looked at showed people in the main were satisfied with the service they received. However, there was no process to evidence how the information from surveys was used to further develop the service. The analysis of the surveys was not shared with people, their family members or their representatives. This meant people were not informed about any planned improvements by the provider based on their comments.

The sharing and promotion of information available to people considering moving to the service, and prospective family members could be improved. We asked the registered manager what information was available to people when they visited to look around Farriess Court. They told us information about the service was available on the providers website. We asked how information was made available to those who may not have access to the internet. We were told they used to provide booklets to people, however these had 'ran out'.

Similarly, we found the availability of information for people already using the service and their family members could be improved. For example, information about advocacy services the complaints process and guidance including contact details about safeguarding were displayed in the conservatory, which was not an obvious place for people to seek out information.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system, passenger lift and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids. All systems had a certificate to evidence they had been assessed as safe at the time of their inspection.

The registered manager told us a family member of the provider regularly visited the service, providing support to themselves. They told us this had been of benefit, specifically in relation to guidance in the use of the recently introduced computer package, which meant all records were now electronically stored and updated.

Staff spoke positively of the support they received from the registered manager telling us they were approachable. Staff confirmed they were supported through regular supervision and that staff meetings were held; however, staff were unsure as to the frequency of staff meetings. Staff told us the meetings were used to share ideas, however staff could not provide an example as to how their views had been listened to, which had resulted in changes to the service.

We joined the staff 'handover', to listen to how staff shared information between themselves about people's health and care. Each person was discussed and any information about health care appointments or changes to their prescribed medicines were discussed. Information was shared as to how people had spent their day, which included their dietary intake.

Staff were confident that the quality of the care they provided was good. This was supported by comments we received from people, family members, friends and health care professionals. Staff had a good understanding of reporting concerns to the relevant people, both internal and external to the organisation.

People, family members and friends in the main knew who the registered manager was and spoke positively about them and their approachability. Information about the service was available on the providers website. The provider is required to display the rating from inspections awarded by the Care Quality Commission (CQC), both within the service and where applicable on their web profile. The provider had displayed their rating within the service and on their website.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure safe care and treatment.</p> <p>People were at risk as radiators and heaters were not covered, placing people at risk of coming into contact with hot surfaces.</p>