Four Seasons (No 11) Limited

Ladyville Lodge

Inspection report

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Date of inspection visit:
26 September 2017

Date of publication:
09 November 2017

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

The unannounced inspection took place on 26 September 2017. At the last comprehensive inspection on the 9th July 2014 there service did not always respond to people's calls for assistance in a timely manner. This was met at our subsequent inspection on 30 October 2015 where the service was rated "good".

Ladyville Lodge provides accommodation and nursing care for up to 38 older people who have nursing or dementia care needs. At the time of our inspection there were 36 people living at the service of which one was on respite. The premises have 2 floors (the ground and 1st floor) with stairs and a lift. Each floor had a mixture of people with nursing and residential needs.

On the day of our visit there was 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.

We found inconsistent practices in relation to infection control. Handwashing was not always completed after direct care in order to prevent the spread of infection. There were also inconsistent approaches to the maintenance of equipment. You can see what action we told the provider to take at the back of the full version of the report.

Staff were aware of the procedures to follow to ensure that medicines were handled safely. However we found one medicine chart had not been dated correctly. Although risks to people and the environment were regularly assessed in order to protect people from avoidable harm, we found some risk assessments were not reviewed and updated monthly. We made a recommendation relating to following record keeping best practice guidelines.

We reviewed incidents and accidents and found they were handled and investigated properly. Learning had been made from an incident of a fall that resulted in an injury and another incident where there had been a delay in referral to the emergency services.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People told us they felt safe. They were supported by staff who were aware of the procedures to protect them from abuse. Staff were enabled to support people effectively by means of training, appraisal and supervision. They attended regular staff meetings.

The provider ensured that there were enough staff available to cover for emergency and absences. There were two vacancies and a few shifts where there had been no full complement of staff.

There were robust recruitment checks which included criminal checks to ensure that staff were suitable to work in the health and social care environment.

Staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards applied in practice. Although we found an instance where a capacity assessment was missing the last page.

People told us that they were treated with dignity and respect and that their wishes were respected. They were aware of how to make a complaint and thought that their complaint would be listened to and resolved by the registered manager.

People were supported to eat and drink sufficient amounts according to their tastes and preferences. They were enabled to access healthcare services where required.

People and staff thought the management team were approachable and open to suggestions made in order to improve care delivered.

There were systems in place to obtain and act on issues raised by people with the exception on two ongoing issues yet to be dressed relating to the dining experience and more wheelchair accessible bathrooms.

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. We found inconsistencies in the risk assessment, infection control and equipment maintenance processes in place.

There were instances where staff were not deployed in all areas to ensure oversight of people in some lounges.

There were safe recruitment practices in place to ensure only staff that had undergone the necessary checks were employed.

Is the service effective?

Good

The service was effective. People told us staff sought their consent before delivering care. Staff had knowledge about the Mental Capacity Act 2005. They were aware of the steps to take if they thought a person's capacity to make specific decisions was limited.

People were supported to maintain a balanced diet. They were supported to access healthcare professionals and healthcare services when required.

Staff were supported by effective induction, supervision, training and appraisals process.

Is the service caring?

Good

The service was caring. People told us they were treated with dignity and respect.

People were encouraged to maintain their independence.

Staff knew the people they cared for, were aware of their preferences, which enabled them to provide care based on people's individual and cultural specific requirements.

Is the service responsive?

Good

The service was responsive. People told us they received care

that was responsive to their needs.

Care was assessed before people started to use the service but was not always reviewed in a timely manner. Care plans outlined people's individual preferences, routines as well as social, emotional and physical needs.

People were able to make complaint without any fears. We found complaints were investigated, responded to and resolved within defined timescales.

Is the service well-led?

Requires Improvement

The service was usually well-led. There were effective systems to monitor the quality of care delivered. However, although systems were in place they were yet to fully address some issues raised by people and inconsistencies in infection control practices and risk assessments.

There was an open and honest culture within the service where staff and people were able to express their concerns.

People, their relatives and staff told us the registered manager was approachable.

Ladyville Lodge

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 unannounced inspection took place on 26 September 2017. It was completed by an adult social care inspector, a specialist advisor with experience in nursing care 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 information we held about the service from previous reports and notifications. A notification is information about important events which the service is required to send to the Commission by law. We had received a complaint and a whistleblowing relating to staffing, infection control and incidents. We also contacted the local authority and reviewed the latest healthwatch review of 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.

During the inspection we spoke with 14 people, the visiting GP and seven relatives. We interviewed a nurse, a senior care assistant, the registered manager, activities coordinator, chef, two care staff, and a housekeeper. We reviewed four mental capacity assessments, 15 medicine administration records, six care records including risk assessments and control drug (CD) book. We also looked a log book with staff verification signatures for medicine administration, medicine fridge and treatment room temperature checks, and controlled drugs checks. We reviewed health and safety checks, gas and water certificates, equipment maintenance, eight staff files, 11 supervision records and a staff training matrix. We also looked at a supervision and appraisal matrix showing at all the supervisions and appraisals completed in 2017.

Requires Improvement

Is the service safe?

Our findings

We found that although risks were identified, they were not always reviewed in a timely manner. There were risks assessments for falls, bed rails, nutrition and skin integrity but not all bed rails and fall risk assessments were reviewed monthly. One person's risk assessment for the use of bed rails had a date of assessment as 10 April 2017and the last review date was 30 May 2017. For another person the reposition chart was not always completed despite having had a tissue viability nurse assessment and an assessment that showed they required repositioning. Repositioning according to staff and what we observed was completed but not always documented to evidence the steps taken to reduce the risk of developing pressure ulcers. For another person the moving and handling risk assessment had not been reviewed or updated since July 2017. A third person had been assessed as at risk of malnutrition. However their food chart was not always completed so as to give an accurate picture of how much they were eating. Steps taken to document and review assessed risks to the health and safety of people were not always recorded leaving people at risk of inconsistent care.

We checked all equipment including pressure relieving mattresses, hoists, slings and hairdryers. Some pressure relieving mattress motors had maintenance dates recorded as May 2016. We found staff were trained and able to use the equipment. However service records were not always in date. We spoke to registered manager about this and they sent us evidence via email to show the provider had changed to two yearly portable appliance testing but had now reverted to annual checks. We also noted that bannister had a loose screw however it had been reported the previous day and we were sent confirmation that the bannister had been fixed. This showed inconsistent safety and maintenance checks to equipment leaving people at risk of equipment that was not safe for use.

We observed inconsistent infection control practices throughout the inspection. We noted hand gel for infection control at the entrance of the service and on one corridor but not in all the corridors. We observed some staff were not in uniform. These staff were observed participating in care without wearing aprons and we did not always observe handwashing after direct contact with people. For example we saw a staff member stroking a resident's dog then push someone's chair follow by making a cup of tea in the lounge without washing their hands. There were several opportunities to hand wash or use gels after direct contact with people but staff did not always wash their hands in order to prevent the spread of infection or bacteria.

The registered person did not always ensure risks were reassessed and equipment was safe for use. Infection control prevention was not always observed as staff did not always wash their hands or wear appropriate clothing in order to prevent the risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

Domestic staff were observed cleaning the floor and yellow 'slippery floor' signage displayed to reduce the risk of people falling. We saw laundry bins on various corridors where linen and clothes were appropriately segregated. We also saw the clinical waste disposal being collected and noted sharps bins were not

overfilled.

We observed call bells were within reach of people whether in bed or in their arm chair. However two people felt the call bells were not always answered promptly. One person told us, "Whenever I ring the bell, it is not always answered quickly as the staff are always busy. I feel they should have more staff." Another person mentioned that sometimes they had to wait a little while to be helped to the toilet, but felt that this was to be expected at times given the number of people needing help. During our inspections call bells were answered within two minutes. However, we also observed that the two separate lounges were sometimes left unmanned although there were people in them. We recommend further action is taken to ensure staff are deployed effectively within the service.

When asked about the level of staffing the registered manager told us there are two vacancies: one nurse and one care staff and another two staff on sick leave: The morning shift had a nurse, a senior care staff and seven care staff. On the afternoon shift there was one less care staff. At night there was one nurse, one senior carer and two care staff. Occasionally there is a twilight carer who worked 5pm-10pm. We reviewed rotas and allocation sheets and found four occasions where the staffing numbers had not been met during the day and another four night shifts during August. However, staff and the registered manager told us an effort was always made to cover shifts with regular or bank staff.

Twelve out of 14 people we spoke with expressed a feeling of being safe. One person said, "There's always someone in the background looking out for you." Another person commented, "They let you get on with things. "They felt they could make their own choices about what they did and when. They said, "I'm happy here". Similarly, visitors were reassured that their loved ones were in safe hands. One visitor whose spouse was unable to use a buzzer said, "Doors are always open and there is always supervision as staff go about their business." Four other visitors whose relatives have complex medical needs and limited communication were all satisfied that safety was paramount. One visitor said, "When I leave, I don't go home worried."

There were safe recruitment practices in place to ensure that only staff suitable to work in a health and social care environment were employed. Checks included proof of identity, qualifications, two verifiable references and disclosure and barring checks. Disclosure and barring checks are checks to ensure staff do not have any criminal records or convictions.
We observed sensor mats in certain rooms which gave additional warning if a person who was at risk of falls was on the move and may need help. A person was sitting in their room in an armchair with a safety mat on the floor said, "I am happy here and want to stay in my room. The mat on the floor is to let the staff know if I am getting up." We saw staff check regularly on people in their rooms to ensure they were safe and appropriate risk assessments in place.

Staff had undergone safeguarding training and were able to explain the different types of abuse and how and where they would report this. One staff told us, "We are quite quick to notify the manager of any allegation of abuse even if it's at night we call them and complete all the necessary documentation. The manager will notify the local safeguarding team and the police if required and the CQC (Care Quality Commission)." There was an up to date policy in place. We reviewed recent safeguarding notifications and found appropriate action plans had been put in place in order to reduce the risk of repeat incidents.

We reviewed incidents and accidents and found they were handled and investigated properly. Learning had been made from an incident of a fall that resulted in an injury and another incident where there had been a delay in referral to the emergency services. For one person who took insulin (a medicine for people living with diabetes), the blood sugar was monitored twice daily and recorded before breakfast and evening meal by the day staff. On occasions when the blood sugar was low appropriate action was taken such as

withholding the insulin, giving a sugary drink and the blood sugar test was repeated until it was within the normal range. This showed that staff monitored people's needs closely in order to maintain their safety.

People told us they received their medicines as prescribed. One person told us, "The nurse gives me my tablets just after meals without fail." We checked the medicine administered record (MARS) charts. We found medicines were managed safely with the exception of some discrepancies seen on one chart which was dated August instead of September. We showed staff the chart. However, the change to the MAR was still not completed at the end of the inspection when we rechecked to see if the required changes had been made. This indicated that safety checks were not always effective as the current weekly and monthly medicine audits in place had not picked up and addressed the discrepancy we found. We recommend best practice guidelines are followed for administering medicines.

There were appropriate procedures in place to store and dispose of medicines safely. Medicine trollies were locked and kept in a locked treatment room. The treatment room and the fridge temperatures were checked daily to ensure medicines were stored at the appropriate temperature. Any medicine that was opened, the date opened was recorded on the bottle so that it can be disposed within the timeframe as per manufacturer's guidance. We checked medicines in the fridge and controlled drugs (CDs) and found they were within their expiry dates. The CDs were checked and were correct when we cross-checked them with the nurse. The nurse was aware of the process of using a CD doom kit for discarding CD drugs which were no longer required. We saw a signature verification sheet of staff who sign for medicines which was updated six monthly and given to the pharmacy that provided the medicine.

There were procedures in place to deal with foreseeable emergencies. During the inspection the emergency call bell started ringing. Staff responded appropriately by checking the alert system running to the bathroom on the ground floor near the reception. The staff checked the person made them comfortable and called the GP who was already present in the service. An ambulance was called and the person was taken to hospital. Fire alarm points with breaking glass were seen throughout, fire exits were indicated in green and fire extinguishers (both water and carbon dioxide) were observed throughout the service on each floor. All oxygen cylinders were full and had been risk assessed with appropriate signage in place to alert staff of the flammable risk.

Good

Is the service effective?

Our findings

People told us that were supported by staff who knew their needs. One person told us, Staff are very good. They are very helpful to me." Another person said, "Staff seem to know what they are doing. hey always give me the support I need." A third person told us, They come and have a chat as they know I prefer to stay in my room." Staff told us handovers were effective and enabled them to keep up to date with any changes in people's needs.

The Mental Capacity Act 2005 (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 homes 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. For people who had a bedrail assessment, a MCA form was completed and a standard DoLS form was completed. We reviewed MCA assessments. One out of four had the page with the date and signature of the professional signing the form missing. This was shown to the registered manager and the clinical lead nurse who thought that it was filed somewhere else but could't find it and said that a new form would be completed. In another person's file a Lasting Power of Attorney (LPA) was missing and this was indicated in the file that the person's son would bring this in. The clinical lead nurse said that they would remind the son to bring it in. There was a DoLS form on another resident's file which expired in 2016. However we were shown correspondence with the local authority to evidence the staff had sought for and were awaiting renewal. Staff had attended MCA training and demonstrated a good understanding of the act and how they applied it in practice.

Staff were supported by means of regular supervision, appraisal and training. Training consisted of online and some practical courses for areas such as moving and handling and medicines. We looked at training records and a training matrix and found the provider was on target to complete training for the year. As of the day of inspection 92% of staff had completed safeguarding training, 83% Mental Capacity Act training, 94% moving and handling, infection control 94% and 90% overall completion of all the required training. Where people were behind on training they were sent reminders. Most staff we spoke with had been working at the service for more than two years and had an induction and regular training. They told us they were happy with the support they received including annual appraisal and regular supervision. One staff told us, "Supervision is useful, another chance to talk about what is working and what could improve."

People felt that they could raise any medical concerns with staff, if they felt unwell in any way and this would be followed up, as a GP was on site every Tuesday. One person said, "I get to see the doctor if I need to." Another person told us, "Yes I have seen the doctor around today and am on the list to be seen today." Care

records contained referrals to external healthcare professionals including dietitian, GP, tissue viability nurse and district nurse for review. The communication book also evidenced each time healthcare professionals visited any person. The GP visited weekly on a Tuesday and had a nurse accompany them to review people. On the day of our visit the GP was accompanied by an Elderly Care Geriatrician to complete their weekly visit. A district nurse also visited and explained they visited twice weekly. Staff were aware of the referral process but if urgent staff could make a telephone referral. People were supported to access healthcare services when required and any advice given was followed in order to maintain their health.

People were supported to maintain a balanced diet. 20 out of the 22 people and relatives we spoke with thought the food was very good. One person said when asked about the food said, "It can't be faulted". Other people described the food as "very good", "lovely", "varied" and "nutritious". One person felt the meals were hot and there was choice but did not always find them tasty. Visitors also commented that the kitchen was very "flexible and accommodating" and would integrate a person's favourite foods/ingredients into the meals which relatives bring in for them. We saw a relative pass on some foodstuff to the kitchen staff. Staff informed us that medicine times had been changed from during meal times to after meals have finished so that people could have protected meal times to provide for their nutrition needs.

Staff were aware of people on special diets and we saw these dietary requirements being followed. Where people had difficulties eating solid food, the meal of the day was pureed down, retaining the flavours and colours of the original meal and presented in appetising manner. Staff assisted people at an appropriate pace and only cleared the table when people were finished. We observed staff offering people hot and cold drinks and some were assisted with drinks in beakers. In people's rooms there were jugs of water, beakers and/or glasses and within their reach. However, we noted that there was one lounge where there was minimum staff and people interaction as staff were mainly either supporting people in their rooms or in the main dining room. We spoke to the registered manager about this and they said they would deploy staff in a way that ensured more oversight of that lounge particularly at meal times.

Good

Is the service caring?

Our findings

People told us they were treated with dignity and respect. They were referred to by their chosen names. One person told us, "They are quite respectful". Another person told us, "They wait for me outside whilst I use the toilet and that gives me the reassurance I need." We saw staff respecting people's privacy and dignity when entering their rooms by knocking on closed doors before entering and asking if they could come in. We observed a member of staff who was dealing with medicines adopt a kneeling posture when addressing people in chairs or bed, so that they were on the same level with them and could maintain eye contact while discussing their medicine and how they were feeling. Another person who was quite depressed about the effects of a recent medical condition said the "manager is nice" and "they look after you here."

Staff spoke of people with affection and were aware of peoples past professions and current hobbies. We saw one staff give a person a glass of milk with their breakfast and the person responded by saying, "I am very predictable aren't I. didn't even have to ask and my milk is here." People knew some staff by name and exchanged jokes where appropriate resulting in a relaxed and calm atmosphere. We saw staff ensure people looked clean after meals by helping some wipe their mouth or change their top if required. Protective aprons were removed soon after meals to preserve people's dignity. We observed staff discreetly support people to maintain their personal hygiene needs. They responded properly to people when they showed signs of agitation such as calling out by going to people and finding means to distract them and calm them down. We saw one person was given a doll and happily engaged in doll therapy cuddling and stroking their "baby". This evidenced staff awareness of supporting people living with dementia.

We spoke with visitors who each had relatives with medical conditions which meant they could not communicate effectively. The relatives said they felt fully involved with care plan decisions about their family member. They were consulted, listened to and in all cases played an active role in the care of their relative. In addition staff were able to communicate with people with complex communication needs using simple language, body language and offering choice via pointing and showing various options.

People we spoke with found staff kind. One person told us, "They are always polite and helpful when I need them." Another person said, "They are very good." One visitor said that staff were 'respectful' in their dealings with people and that, "it compared well to other similar facilities." Another visitor described the 'warmth' which they experienced from staff. We observed staff speaking pleasantly and courteously, addressing people by name, sometimes with a little extra exchange about something that happened earlier on in the day, a previous day, or simply enquiring about a relative.

People were supported to be comfortable and pain free during the last days of their life. Staff told us they worked with the GP and district nurses to support people and their families. The GP undertook review of all palliative persons and staff ensured end of life care plans and wishes were documented so that they could be adhered to when people could no longer express their wishes. When a person passed away, a small memory book, consisting of relevant photos, was given to the relatives as a memento of their loved one. Where possible a member of staff attended the funeral.

We observed several instances where people were encouraged to maintain their independence. These were when mobility aids were kept in close proximity to ensure people could get to them when needed. Staff also cut up some people's food and gave others adaptive utensils such as beakers to enable them to eat and drink independently. One person told us, "It's a partnership, they only help me with things I can't do such as wash my back and fiddly buttons."

People were involved in making decisions about their care. They told us they chose what they wanted to do and where they wanted to go. One person said, "Yes I decide if I want to go to the garden or stay in my room" They were provided with information by the service which was displayed on noticeboards and within the "service user guide". Staff told us people were signposted to other organisations if they wanted independent advice and information about specific issues such as health conditions.

Good

Is the service responsive?

Our findings

People told us they had been involved in planning their care and knew they had a care plan. One person told us, "They [staff] come and ask if everything is ok or if I want anything changed. I remember being asked a lot of questions just before I moved in." Another person told us, "They have a big folder they write everything in. I have read and signed some on it" Care needs were assessed and care plans were developed with people and their relatives in manner that reflected their physical social and emotional needs. We checked care plans with complex care needs to ensure that their appropriate care was met. The records showed that some people had an initial pre-admission assessment completed prior to transferring to the service to ensure that their needs could be met. Others had identified dependency needs once admitted and all had care plans to meet their needs. However, not all care plans and risks assessments were consistently reviewed monthly. We recommend further guidance is sought to ensure risk assessments and care plans are completed in a timely manner.

People told us they were treated as individuals and that they could complain or raise concerns if needed. One person said, "Yes if I have any complaints I tell the manager. So far any issues have been resolved." People were satisfied that they were listened to, although one person said that the outcome was not satisfactory. We spoke to the registered manager about this after our visit and they were still in the process of resolving it as it related to a fixture and fitting that needed to be adapted to meet the individuals need. We reviewed the complaints log and found complaints were responded to and resolved in a timely manner. Staff were aware of the complaints process and told us they refer complaints to the registered manager.

People and staff told us family and friends were always very welcome. There was a constant flow of visitors throughout the day. Some visitors ate lunch with their relatives and the atmosphere was friendly and relaxed. One relative told us, "I come twice a day without fail and am always met with a smile." A person said that in general staff 'seemed happy and worked together well' and their family had noticed this. We saw relatives help themselves to tea at a station located in the dining room.

People were supported to participate in activities. There was an activities co-coordinator who was assisting with breakfast when we arrived and also assisted people at lunch times. People and relatives spoke of an event that had occurred the Saturday before our inspection and told us they had enjoyed the music and food. One person told us they didn't want to go out of their room and enjoyed knitting. Another person told us, "I come in and out of the lounge for meals and sometimes enjoy sitting in the garden. Most times I prefer to sit in my room. I can also open a door in my room that leads out to another part of the garden." Two people thought the activities could be improved. One person told us, "Although there are always lots going on. Personally I prefer more outside entertainment." Another person told us, "Weekends can be dreary if you don't have visitors. However, this must be one of the best places."

We looked at people's 'My Choices Book,' a booklet used to provide a profile of the people's preferences. In most cases the general information about the individual was recorded but the more detailed questions about hobbies and interests was often left blank. However, where people and/or their relatives were more confident and vocal they made suggestions about what they would like to do. For example, the relative of

one person, with a particular interest in birds, asked if they could put up bird feeders on their relative's windows and this was allowed. Another person, who liked gardening, asked if they could be involved with the garden and this was allowed and resulted in an interactive garden with scarecrows, colourful pot plants and several seating areas. Similarly there was now a small resident dog on site which was seen giving pleasure to a number of people. We were told by staff and the person confirmed the dog had been provided by the registered manager following a conversation with a person who had had a dog, and who missed an animal presence in their life. The above showed an effort was made to engage people in activities that suited them and helped them maintain their hobbies and interests resulting in better quality of life and well-being.

We spoke to the activities coordinator who had knowledge about people's preferences and told us they went with what people wanted to do for the day. On regular intervals people went into the garden and at one point a quiz was taking place in the garden. We saw an in-house 'shop' on a trolley in response to people wanting to buy sweets and toiletries. The activities coordinator went round with the trolley and we saw people choose what they wanted. We saw displays and pictures of previous events held at the service, trips to the seaside and the garden centre. Forth coming events such as the Macmillan coffee morning were also on display.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff thought any issues they raised were listened to and acted on most of the time. One person told us, "The manager is quite good. If you tell her something she gets it done quite quickly." Another person told us, "So far so good except one little issue which the manager is working on." There was a support group which met on an ad hoc basis and referred up any issues that were flagged. The group's founder told us they were satisfied that they were listened to and could influence things. For example, they had suggested that the garden could have better use. They had been given permission with others to develop it as a focal point and place for quiet reflection for both people and visitor use. This was confirmed within the minutes we reviewed our observations of the garden and by other people, staff and the registered manager.

However, two people and two relatives felt there were two ongoing issues still to be addressed as follows. One visitor had raised the point that only two toilets with wheelchair access were not enough for the number of people needing that facility. They felt they had been listened to, but as yet there is no certainty that anything could change. Similarly, another visitor reported that they had commented that the dining area 'is too small for the numbers involved' and that when in full operation, it was difficult for people, whether on a frame or in a wheelchair to get out quickly and safely if they needed the toilet urgently. This was agreed with, but clearly depended on many factors including time, funding and whether practice in the service can be changed. We observed people waiting to use the wheelchair accessible toilet similarly although some people ate in the other two lounges and others in their rooms, the dining room was full and had little room to manoeuvre safely. We spoke to the registered manager about this and they told us there were plans to resolve these issues. We recommend that the service seek further ways of communicating changes effectively.

The current systems in place to monitor the quality of care delivered had identified but had not yet fully addressed inconsistent infection control and frequency of maintenance checks. We recommend the service follows best practice infection prevention guidelines.

Monitoring checks included monthly sling checks, bedrail checks, staff files, health and safety, information governance and medicines management. The quality of dining experience was also monitored every three months with feedback used to amend the current menus. The chef told us how they used feedback from the dining experience audit to improve meal times. The registered manager completed unannounced night visits and ensured any actions were addressed. For example the last check found an issue with cleanliness and staff not being allocated a break time. This had been addressed with the nurse in charge of the night shift.

The registered manager was visible and hands on in the day to day operations and accessible to people and visitors. All the staff we spoke with felt that they had good support from the registered manager and that there was training in place. They thought the registered manager was open and fair. We observed good interactions between the registered manager with people, their relatives and staff.

The service had a registered manager, an acting deputy and a clinical lead. The registered manager was supported by the regional manager who completed monthly audits. We saw a quality assurance process in place where feedback was obtained from people and their relatives via an electronic system.

Staff were aware of their role and the importance of team work. Although staff were allocated to particular people we saw them work as a team. Staff expressed the ethos of the service of one where the staff work together as a team. One staff told us their personal philosophy that to work in care 'it has to be in your heart' they believed this was shared across all the staff. The same sentiment was echoed by the registered manager and other staff we spoke with.

Staff felt they were supported by the registered manager and the management team to complete their work. In addition to training and supervision there was a staff of the month award to recognise staff who went the extra mile to ensure people received care that suited their individual needs. Staff who had received this award told us they appreciated the recognition.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure risks were reassessed and equipment was safe for use. Infection control prevention was not always observed as staff did not always wash their hands or wear appropriate clothing in order to prevent the risk of infection.