

Appletree House Residential Care Home Limited

Apple Tree House Residential Care Home Limited

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 22 September 2015 and was an unannounced inspection. The previous inspection on 14 November 2013 was a follow up inspection and we found the regulation we assessed was being complied with at that visit.

Apple Tree house is registered to provide accommodation for persons who require nursing or personal care for up to 12 people with learning disabilities.

On the day of the inspection there were 12 people living at the service. The service is located in the market town of Beverley in the East Riding of Yorkshire. It is close to the local shops and offers access to local transport routes.

There was a manager in post who had registered with the Care Quality Commission (CQC) in September 2015. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers,

Summary of findings

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.

Medicines were administered safely by trained staff and the arrangements for ordering and storage were appropriate. However we saw there was not an effective stock control system in place and errors were not identified.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, some people who used the service had been deprived of their liberty and no applications to authorise this had been made to the local authority.

People who used the service, relatives and staff told us that the home was well managed. We saw that although the registered provider had systems in place for monitoring some parts of the service they were not always effective.

We saw that people had person-centred care plans in place to instruct staff on how best to support them and meet their needs. These were clearly written. However, we saw these were not always consented to or regularly reviewed. We have made a recommendation about this.

We found that people were protected from the risks of harm or abuse because the registered manager had

effective systems in place to manage issues of a safeguarding nature. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff had been employed following the registered providers recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed.

We saw that people enjoyed premises that were suitable for their purpose. The environment was well maintained, comfortable and in a safe condition.

Staff confirmed that they received induction training when they were employed and told us that they were happy with the training provided for them. The training records evidenced that most staff had completed training that was considered to be essential by the service.

We found that people were cared for and supported by kind and caring staff that also provided clear boundaries for acceptable behaviour. Staff offered advice and guidance to assist people to lead a purposeful and fulfilling life.

People were supported to undertake activities and employment of their choosing and were able to complain if they felt necessary.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Medicines were administered safely by trained staff and the arrangements for ordering and storage were appropriate. However, we saw there was not an effective stock monitoring system in place and errors were not identified.

People that used the service were protected from the risks of harm or abuse because there were safeguarding systems in place. Staff were trained in safeguarding adults from abuse and they were aware of their responsibilities.

Staff were recruited using robust policies and procedures.

Requires improvement



Is the service effective?

The service was not always effective.

People and staff communicated well. The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, we found that Mental Capacity Act (2005) guidelines had not been fully followed.

People were supported by trained and competent staff that received induction to their roles and were supervised by the registered manager.

People enjoyed premises that were comfortable and suitable for their purpose.

People had their health and social care needs assessed met. People who used the service received additional care and treatment from health professionals in the community.

Requires improvement



Is the service caring?

The service was caring.

People were cared for and supported by kind, caring and understanding staff. Staff offered advice and guidance to assist people to lead a full life.

People told us that staff were caring and this view was supported by the visitors we spoke with.

The staff were knowledgeable about people's support needs.

Good



Is the service responsive?

The service was not always responsive.

People had care files in place to instruct staff on how best to support them and meet their needs. However, these were not always consented to or reviewed regularly.

Requires improvement



Summary of findings

People we spoke with were aware of how to make a complaint or raise a concern. They told us they had no concerns but were confident if they did these would be looked into and reviewed in a timely way.

People were encouraged and supported to take part in activities and employment.

Is the service well-led?

The service was not always well led.

The systems in place to monitor and improve the quality of the service provided were not effective.

The systems in place to seek feedback from people and their relatives about the service provided were not effective.

The management arrangements at the service were satisfactory.

Staff and people who used the service told us they found the registered manager was supportive and felt able to approach them if they needed to.

Requires improvement



Apple Tree House Residential Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 September 2015 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department and Safeguarding Team.

During the inspection we spoke with three people who lived in the service, two members of staff, the registered manager, a visiting relative and a visiting professional.

We spent time looking at records, which included the care files for two people and the financial records for twelve people who used the service. We looked at the recruitment, induction, training and supervision records for three members of staff and records relating to the management of the service. We spent time observing the interaction between people and staff in the dining area during mealtime and in two people's bedrooms (with their permission).

Is the service safe?

Our findings

We assessed the medicine management systems used at the service. The registered provider used a monitored dosage system where a monthly measured amount of medicine was provided by the pharmacist in daily doses, as prescribed by the GP. The service had an ordering system that was completed on a monthly basis on the medicine administration records (MAR) for each person. There was suitable storage of controlled drugs (CDs) and a CD record book. We checked one sample of entries in the CD book and the corresponding medication and saw that the records and medicine in use balanced. Training records demonstrated eight of the 15 staff had undertaken appropriate training in medicines and six staff were enrolled and due to complete training. However, one staff member had completed training in 2011 and it was not clear if this member of staff had received updated training since that time.

Medicine cabinets were secured in each person's room. We looked at the MAR for three people who used the service. These included details of any 'as necessary' medicines. We noted no gaps in recording for administering medicines. One person's medicine had been handwritten by staff but had no signatures to confirm the details. Signing and countersigning of handwritten records is considered best practice as the second check helps to reduce the risk of errors occurring. We completed a check of one person's medicines in their room with their permission. The sample we checked had some discrepancies including loose tablets. We checked the corresponding MAR record and found there was no indication of how many of the tablets had been carried forward or booked into the service. We asked the staff to show us how the service monitored stock. They told us each person's medicines were counted and recorded each month. We were shown the audit for August 2015. However, there was no date to show when this had been completed and these were not periodically audited by the registered manager. We saw from the records that the last recorded count did not tally with the amount of tablets in the service at this inspection. This meant there was not an effective stock audit system in place and errors were not identified.

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

During this inspection we did not discuss safety with anyone who lived at the service. However, we observed throughout the inspection that people appeared to be relaxed and comfortable with the staff at the service. We asked a visiting relative if they felt their family member was safe. They told us, "Yes, [Name] is definitely safe." We spoke with a visiting health professional who told us they felt people at the service were safe.

We spoke with the local authority safeguarding adult's team prior to the inspection. They told us they did not currently have any concerns with the service. We saw the registered provider had a safeguarding policy in place which was last reviewed in April 2015. Staff we spoke with were able to demonstrate what they would do should they identify possible abuse. They told us, "I would speak with my manager and then the safeguarding team. I know we have a whistleblowing policy," and "I have been in touch with the safeguarding team as I was concerned about a person. A safeguarding referral was put in. Previously I had a concern about medicines and I came straight to my manager and raised it." We were able to confirm in the training plan that staff had completed training in safeguarding adults.

We found that the registered provider had information about the local authority safeguarding risk management tool. The registered manager kept a safeguarding log which included evidence of discussions with the local safeguarding authority, referral forms, supporting evidence and any internal investigations carried out. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We looked at the way risks were managed at the service. We saw risks associated with the person's care were recorded in people's care files. We saw risk assessments included: medicines, shaving, meals, taking a shower, use of a hoist and use of bed rails. This meant people had support to help them keep safe.

We saw that some identified risks were not being reviewed on a regular basis. For example, in one person's records we saw a medicine risk assessment was last reviewed in November 2014 and prior to this date reviews were completed on a monthly basis. This meant that any changes may not be identified and addressed at an early opportunity.

Is the service safe?

We discussed this with the registered manager who told us they had recently taken up the position of registered manager and the service was currently updating people's care files to be more personalised and that this work will include reviewing all people's risk assessments. The registered manager told us the local authority contracts and monitoring team had provided them with risk assessment templates and they were in the process of updating all risk assessments as part of this work. We saw evidence of the one person's care plan we were told had been updated. We saw all of the person's risks had been assessed in August 2015.

We looked at documents relating to the safety of the premises. These records showed service contract agreements were in place which meant the premises and any equipment was regularly checked, serviced at appropriate intervals and repaired when required. The checks included electrical installation, gas safety, firefighting equipment and portable electrical items.

We asked staff about arrangements in place in the event of a fire. We were told the procedure was to keep calm, access the service signing in sheet to check who was in the building and evacuate according to the procedure to the muster point. We saw the last check of the fire system was September 2015 and deficiencies and evaluation of actions was recorded. These environmental checks and maintenance work helped to ensure the safety of people who used the service.

The registered provider had a business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. This was last reviewed in January 2015.

Accidents and incidents that occurred at the service were recorded. However, there was no evidence that accidents and incidents had been analysed since 2014. This meant that any trends may not have been identified at the earliest opportunity.

We looked at three staff recruitment files. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These measures ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

During the inspection we saw five staff on duty throughout the day. One person who used the service had 37.5 hours of dedicated one to one support per week to enable the service to meet their assessed needs. The registered manager told us there was three staff on duty during the hours of 7am until 10pm. From 10pm to 8am there was two night staff: one sleeping and one waking.

We looked at the duty rota from 20 July to 20 December 2015. The rotas showed us there were staff on duty throughout the day and at night, with a skill mix to meet people's assessed needs. The staff team consisted of team leader, support workers, night workers and ancillary workers. We checked which staff were on duty during the inspection and found that this corresponded with the duty rota for that day.

We asked one person that used the service if they felt there was enough staff to support them. They told us, "Yes sometimes there are four on a day and three on a night but we don't really need them as we go to bed." One visitor told us they felt the staff were in ample numbers to support people using the service. We asked staff if they felt there was enough staff at the service to meet people's needs. They told us, "Sometimes I feel like there isn't enough but I think overall there are enough of us. If not, we can get staff to come in," and "Yes, there is enough staff."

Is the service effective?

Our findings

We asked a relative if they were involved in decisions about the care of their family member. They told us, “Yes they always talk to me.” One person that used the service told us, “Staff always ask me do I want to do this or that.”

In discussions with staff, they were clear about how they gained consent prior to delivering care to people that used the service. They told us, “People who are independent have full input. I always talk to people,” and “One person I support loves the shower and I know [Name] is happy to have a shower as [Name] will laugh. Everything is up to the person.”

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. The registered manager told us they had an understanding of the requirements and principles of MCA and DoLS and our discussions supported this. However, two people’s care files had DoLS application paperwork that indicated they had been submitted to the local authority in September 2014 for consideration. We could not see any authorisations or outcomes recorded. There was no evidence of any MCA assessments or best interest meetings for either of the people to support the DoLS applications. Best interest meetings are held when people do not have

capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person’s care meet to make a decision on the person’s behalf. We discussed this with the registered manager who agreed to speak to the local authority. The local authority safeguarding team confirmed that neither of the applications for authorisation had been received. This meant the people using the service may have been deprived of their liberty unlawfully for a considerable amount of time as no authorisations had been granted. The registered manager submitted two urgent authorisations for DoLS during the inspection. The local authority safeguarding team confirmed they had received and were processing both applications whilst we were at the service.

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

We looked at the training plan for the service and found staff had completed training in moving and handling, fire safety, first aid, safeguarding, MCA 2005 / DoLS, infection control, food hygiene and health and safety. Additional training had been completed in specific topics which included epilepsy and working with people with learning disabilities. One member of staff we spoke with told us, “I have done team leader training. I am currently working on my NVQ 3 (national vocational qualification). I have done safeguarding, medicines, health and safety, fire, first aid and mental health awareness.”

We looked at the induction records for three members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the service. We saw staff had completed the Skills for Care induction programme. Skills for Care are a nationally recognised training resource. We saw the induction included the role of the health and social care worker, communication, safeguarding, equality and person centred support. One member of staff told us, “I completed Skills for Care induction and covered medicines, people’s care files and records.” This meant staff were competent and skilled in providing the support and care people that used the service required.

Staff told us that they received supervision sessions every month to six weeks. Supervision is a process, usually a

Is the service effective?

meeting, by which a service provides guidance and support to staff. They told us, “I have some good ones” and, “I am supervised every six to eight weeks.” We saw supervision records were up to date.

People who used the service told us that they had good access to GPs and other health care professionals. One person told us, “Yes, I see my dentist every six months and my GP.” Relatives told us that they were kept informed of any changes to their relative’s health and well-being. One relative told us, “I am always involved if [Name] goes to the GP or hospital.”

People had their health care needs documented in their care files. Information included details of health care checks (dental, optical, hearing and GP), medical diagnoses and information about any allergies. This meant people using the service had their health care needs met and staff had easy access to information.

People we spoke with told us they were satisfied with the provision of food and drink. We saw a pictorial menu board displaying the meals available on the day of the inspection. One person told us, “They know what my likes and dislikes are, yes. I go and make my own drinks; there is a kettle and

everything.” A relative told us, “If there is something they don’t like they do something else.” We saw some people chose to eat their meals at the dining tables and others preferred to eat either in the lounge or in their own rooms. We asked people who used the service what that thought of the meal. They told us, “Its chicken casserole” and, “It’s gorgeous.” We saw the meal looked appetising and hot.

There was nutritional information in people’s care files that included likes and dislikes and nutritional risk screening. There were no concerns raised by people about food provision as all meals were home cooked from fresh. Checks of the fridges and freezers showed an ample supply of healthy ingredients, vegetables and treats were available to create healthy and nutritious meals. Items in the freezer were clearly labelled and dated.

People had their own bedrooms and the use of a bathroom and communal living and large dining/kitchen and laundry facilities. The service had a secure courtyard garden. All areas we looked at were well maintained, furnished and decorated to a good standard. A relative told us the service was “beautiful and clean”.

Is the service caring?

Our findings

During the inspection we observed that staff had a considerate and caring manner with people who used the service and they knew people's needs well. We observed good interactions between the staff and people, with friendly and supportive care practices being used to assist people in their daily lives. One person who used the service told us, "It's very nice; in fact it couldn't be better. The staff are very kind here, I am well looked after. There was one night I couldn't get my breath and the staff stayed with me all night." A relative told us, "Yes the staff are very caring. It's the best crowd they have ever had."

We saw that visitors came to the service throughout the day and were made welcome by staff. It was apparent that these were regular visitors who had a good relationship with the staff and the registered manager. A visiting professional told us, "It's the best it's ever been. It feels warm, homely and friendly. The people that live here appear more settled and it seems more comfortable."

We observed one person who used the service having a discussion with the registered manager. The person was offered a verbal choice of evening meal and given lots of time and gentle prompts to make their choice. Structured reassurance was given about an upcoming event the person was asking about which appeared to give the person piece of mind and reduce any worry. This meant staff could recognise trigger points and safely manage these times of anxiety.

We saw that staff called each person by their name and that they were all familiar with each individual. One person we spoke with told us they were happy that their privacy and dignity was maintained. We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering and holding discussions with people in private when required.

Staff told us that they read people's care files and these included information that helped them to get to know the

person, such as their hobbies, interests, likes and dislikes. They told us, "One person loves to go to the pub and we have advised [Name] to come home around 10-10.30pm for safety. [Name] comes home when they choose though as it's up to [Name]" and, "[Name] prefers to have a shower before breakfast and then after breakfast have their hair dried." This indicated people were being supported to live their chosen lifestyles and staff were aware of their different routines.

Staff were able to describe people's preferred methods of communicating. They told us, "[Name] displays excitement and laughter. This means they like the person they are with. [Name] will scream when upset" and, "If [Name] is enjoying food they will use a certain word. If they don't like the food they will not eat it and we know if [Name] is enjoying the shower as they will sit down and splash in the water."

A visiting professional told us that they trusted the service would always contact them when they felt it necessary and communication was improving. They told us, "In the past I have had concerns but over the last few months I am impressed with the contact. They spoke to me this morning and I came in this afternoon. It's improving all the time." When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included family and friends, and any health or social care professionals involved in the person's care. This meant that all of the relevant people were kept up to date about the person's general health and well-being.

People's care files included information for staff regarding the way in which they were to provide care and support to people. They included 'Good day/bad day' and 'How to support me'. One person who used the service told us, "I do know they care very much. They say do you want to go here or there and ask what I think of places." We saw in one person's care file they had on-going support when needed from an advocate. An advocate is a person who represents and works with a person or group of people who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Is the service responsive?

Our findings

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. We looked in detail at two of these files. We saw that the care files/plans we looked at had not been signed by the person using the service or their relatives to say it had been discussed with them. This meant we could not determine whether people living at the service and their relatives were fully involved in the planning of their care. We discussed this with the registered manager who told us as part of the review of all people's care files consent would be obtained.

We saw in care files that assessments had been undertaken on nutrition and mobility so that a person's level of dependency could be identified. This information had been used to develop care plans that reflected people's individual abilities and needs. Care plans were personalised and recorded what was important to the person concerned and how to support them on both good and bad days. We saw a section called 'About Me' which recorded life history, personal hygiene preferences, mealtimes, travelling, activity and any dietary needs.

We saw that sections of care files were not reviewed regularly nor signed by the person completing them. For example, one person's care file recorded they had seen their dentist and GP. However, there was no date or signature to indicate when this was. We saw one person's personal emergency evacuation plan (PEEP) had been implemented in September 2013 and had not been recently reviewed or signed on completion. A nutritional risk screening had been completed for the person with no date. This meant that people's care plans were not continually updated to reflect people's changing needs and to ensure they received appropriate care.

We observed people using the service were able to make their own choices, such as where to eat their meals and where to spend their day. We saw one person choosing to spend time in their own room whilst another person was supported to go out shopping to purchase a new bag for their holiday. Staff told us, "Everything is up to the person

and what they want to do" and, "They tell us what they want to do." One staff member told us a person who used the service had recently had an accident and this had upset them. They told us they talked through the accident with the person to get it off their chest and this made them feel better. We were able to confirm this in the persons 'consultations' records in the care files. This showed that staff listened to people using the service.

People told us about available activities. They said, "I go out and do woodwork. I like gardening and I did a course about fruit and vegetables. I do the gardening here." The registered manager told us people using the service had varying interests. They told us people went horse riding, to the gym, swimming, play football and enjoyed games consoles and sensory sessions. We saw people had a plan of activity in their care files and were able to confirm the activities of their choice. For example, one person spent time as a disc jockey (DJ) at a local club, swimming and going to the gym. Staff told us people who used the service were very individual and had a range of interests and jobs. They told us, "Two people have jobs with local businesses and another person goes to a work link service." We saw people's work and activity was summarised regularly by their named key worker.

People who used the service told us that they would not hesitate to make a complaint. They said, "I would speak to [Name] that's the one who's in charge of everything. Yes I would complain to the boss." Relatives told us they would feel comfortable in raising concerns. One person said, "I know what the complaints procedure is. I would come straight to the office."

We saw the registered provider had a complaints policy and the registered manager kept a log for all complaints made with forms ready to be completed should anyone wish to raise a complaint. We checked the complaints log and saw that no complaints had been received by the home during the previous twelve months.

We recommend that the registered provider ensures all care files are reflective of people's needs, reviewed regularly and the consent of people using the service is obtained.

Is the service well-led?

Our findings

As a condition of their registration, the service was required to have a registered manager in post. There was a registered manager in post at this inspection who was registered with the CQC.

The registered manager was present during the inspection and was able to assist with the inspection and locate documents that we required promptly. All records containing details about people that used the service, in relation to staff employed in the service and for the purpose of assisting in the management of the service were stored safely and securely. We found that the registered manager was honest with us regarding any shortfalls in the service delivery.

Services that provide health and social care to people are required to inform the CQC of specific events that happen in their service. The registered manager had informed the CQC of significant events in a timely way. This meant the service took this responsibility seriously and meant we were able to check that appropriate action had been taken.

We saw that the registered provider had some audits in place to check that the systems at the home were being followed. We saw completed audits on fire records, first aid, finances, medicines and controlled drugs. However, we saw that these individual audits were not evaluated and had failed to identify issues we found during the inspection such as incorrect medication stock, MCA guidance not being followed and best interest decisions, DoLS and care plans not consented to or being regularly reviewed. The systems in place did not ensure that people's care delivery was considered using a quality monitoring and assurance system to identify where improvements were needed. This meant that they may not have been driving continuous improvement of the service.

We spoke with the registered manager about the culture of the service and how they made efforts to ensure people who used the service and their relatives were able to discuss issues openly. They told us they had sent out satisfaction questionnaires to people's relatives and received no responses. They explained they had rung families up individually and there were no current issues. We did not see any evidence of this. A relative told us, "No, we don't have relatives meetings. I don't know when the last one was."

We saw meetings were held with people using the service. However, we saw no evidence of satisfaction questionnaires or other methods of gaining people's views from people using the service. One person who used the service told us, "No, well I say no but yes they do meetings but I don't want to go to them." We saw the last meeting for people who used the service was in July 2015. We saw people had chosen to have a 'garden party', discussed activities, menus and safeguarding. The registered manager told us the meetings used to be on a Friday every two to three months. This was identified as not working for people and this had changed to a Thursday tea time when more people were at home. We saw people's relatives had been introduced to the registered manager through a letter sent in July 2015.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager had recently registered with CQC. They told us that when they had started at the service on November 2014 paperwork and people's care files had required improving. They had attended a course on person centred care in June 2015 and were in the process of updating all people's care files to be more person centred.

People we spoke with were complimentary about the registered manager. They said, "There is a very good atmosphere. Everybody is speaking to each other and the best thing is my bed and peace and quiet." Staff told us they felt supported by the registered manager and praise was given to them for doing a good job. Comments included, "Verbally the manager doesn't speak down to us. They care and their door is always open now. It feels like a home, it is their home and it's ever so relaxed now" and, "I am told in my supervisions that I am doing well. The service is run very fairly, when I first started here the office door was always shut and now it's always open." A relative told us, "The manager is a darling, [Name] is good."

People that used the service were encouraged to use community services as much as possible to experience a variety of interactions with other people. They usually went out for shopping, to social clubs, to their employment and to church.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.</p> <p>People who use services were not protected from the risks of unsafe treatment because there was no effective system in place to identify medicine inaccuracies.</p> <p>Regulation 12 (2)(g)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.</p> <p>People who used the service were not safeguarded because the provider had not acted in accordance with the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS). The service had not submitted or received standard authorisations when depriving people of their liberty.</p> <p>Regulation 13 (5)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Good governance.</p>

This section is primarily information for the provider

Action we have told the provider to take

People who used the service were not assured of a quality service because there was no effective system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The service did not evaluate and improve their practice effectively.

Regulation 17 (2)(a)(f)