

The Sandwell Community Caring Trust

Hall Green Care Home

Inspection report





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West Bromwich
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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?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

About the service

Hall Green care home is a residential care home that provides personal care for up to 62 people, aged 65 or over, most of whom are living with dementia. The service was provided over three floors. People on the first and second floors lived permanently at Hall Green. There was an assessment unit on the third floor, where people were temporarily admitted from hospital or from the community to assess their needs. This took place over a four to twelve week period, prior to making more permanent arrangements to meet their care needs. 51 people lived at the home at the time of the inspection.

People's experience of using this service and what we found

We have found evidence that the provider needs to make improvements. People were at risk because medicines were not always managed safely and in accordance with best practice guidelines. People did not always get their medicines as prescribed or when they needed them which put their health at increased risk. We asked the registered manager to take some immediate steps to reduce these risks, which they did, and to make further improvements.

Some of the providers quality monitoring systems were not fully effective. This was because they did not take effective action to make the required improvements to address risks identified.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We have made a recommendation about improving records of best interest decision making.

People did not have access to safe outside space because the gardens were poorly maintained. This reduced people's ability to move around outside independently.

Please see the Safe, Effective and Well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

People were supported by caring and compassionate staff who treated them with dignity and respect.

People and relatives felt the service was safe. Staff demonstrated an awareness of each person's safety and how to minimise risks for them. There were enough staff who worked flexibly to ensure people received care and support in a timely way.

People were supported by staff who received regular training and supervision to provide them with the skills and knowledge to meet people's needs. Staff worked in partnership with local professionals to provide effective care, support and treatment.

People received personalised care responsive to their needs. Recent improvements had been made in the variety of activities for people. Further improvements were needed to make activities more personalised for the needs of people living with dementia.

People's concerns were listened and responded to. Accidents, incidents and complaints were used as opportunities to improve the service.

People, relatives and professionals gave us positive feedback about leadership and the quality of people's care. They said the registered manager was approachable, organised, and acted on feedback.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: The last rating for this service was Good. (Report published on 04 May 2016).

Why we inspected: This was a planned inspection based on the previous rating. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Follow up: We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Hall Green Care Home

Detailed findings

Background to this inspection

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

Inspection team: An inspector, assistant inspector, a member of the medicines team and an Expert by Experience visited the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses care services for older people.

Service and service type: Hall Green is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced. We visited the service on 4 and 5 June 2019.

What we did before the inspection: We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 17 people and nine relatives to ask them about their experience of the care provided. We looked at five people's care records and reviewed seven people's medicine administration records. We observed medicines administration. We spent time in communal areas and observed staff interactions with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to

help us understand the experience of people who could not talk with us.

We spoke with the registered manager, deputy manager, and with 15 staff, which included care, housekeeping, maintenance and catering staff. We looked at five staff members files around staff recruitment, supervision, appraisal and at staff training records. We also looked at quality monitoring records relating to the management of the service. We sought feedback from commissioners, health and social care professionals who worked with staff at the home. We received a response from five of them.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always managed safely because people did not get their medicines as prescribed or when they needed them. We identified concerns about medicines management on two of the three floors during our visit.
- People did not always get their medicines as prescribed or when they needed them. Medicines were offered to people at set times. If people were sleeping when the medicines round was carried out, they often missed their medicines. Medicine Administration Records (MAR) showed people were not routinely re-offered their medicines when they awoke. This meant some people were not receiving all doses prescribed for their health needs. For example, people were regularly missing medicines prescribed for treating high blood pressure, anxiety, pain relief and mental health needs.
- Where people needed medicines "when required", individual protocols lacked details. There was no information for staff about how to identify if people needed those medicines, for example, if they could not communicate verbally. Although staff were able to describe signs they looked for, these were not recorded. This could lead to inconsistent practice.
- We found one person was regularly administered a "when required" medicine at more frequent intervals than was prescribed by their GP, which was a risk to their health. Another person was not receiving eyedrops as documented in the care plan.
- Where people needed their medicines covertly (disguised in food or drink), staff did not have detailed information available about how to prepare and administer these medicines safely.
- There was a lack of detailed information about where and how frequently prescribed creams should be used, where they should be applied and frequent gaps in administration records.
- The registered manager had identified concerns about lack of staff knowledge, competency concerns and about poor record keeping when they first came to work at the home through medicine audits in June and July 2018. In response, they arranged for all care staff who administered medicines to receive updated training and a competency assessment.
- Where concerns about individual staff practice had been identified, staff involved were given additional training, supervision and their performance monitored. In April 2019, discussion of recent audits of medicines at a staff meeting showed several medication errors had occurred over the past few weeks. The registered manager impressed on staff the need to be observant, follow medicines management procedures, take time and not become distracted.
- The registered manager felt practice had been improving over the past few months in response to these steps. However, our findings showed people remained at risk because so far, these steps had not brought about the required level of safety improvements needed in medicines management.

These risks were a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

- On the first day of the inspection we gave the registered manager feedback on the areas of greatest concern in medicines management. We highlighted areas of poor staff practice asked them to take further immediate steps to improve safety in medicines management. The next day, they outlined further immediate steps they had taken to reduce those risks.

Assessing risk, safety monitoring and management;

- People had personalised risk assessments that guided staff on ways to minimise risks as much as possible. For example, following an increase in notifications about falls, we looked in detail at how the service managed people at high risk of falling.
- Staff had undertaken further training in falls prevention. People identified at high risk of falling had detailed care plans which showed control measures in place to minimise risks. For example, ensuring people had good fitting footwear, checking on people regularly and reminding them to use any mobility aids.
- Environmental risk assessments highlighted potential hazards and ways to minimise risks around the home. There was an ongoing programme of servicing, repairs, maintenance and refurbishment. For example, reducing trip hazards by keeping rooms free of clutter. Following a fire risk assessment, improvements in fire safety were made to meet fire regulations.

Learning lessons when things go wrong

- Accidents and incidents were reported, which the registered manager monitored to see if additional steps were needed to keep people safe, and to identify any trends. Where monthly analysis highlighted anyone at increased risk of falling, additional safety measures were taken. For example, checking on people more regularly to anticipate their needs.

Systems and processes to safeguard people from the risk of abuse

- People felt safe living at the home and with the staff who supported them. People and relatives commented; "The home is welcoming and safe," "I have no worries," and "I can't fault them."
- People were protected because all staff received training on how to recognise and report signs of abuse. Staff had regular safeguarding training and demonstrated a good understanding of how to recognise and report suspected abuse. They were confident concerns reported were listened and responded to which made sure people were protected.
- Where safeguarding concerns had been identified, staff worked in partnership with the local authority and others to protect people.

Staffing and recruitment

- There were enough staff on duty to keep people safe and meet their needs. People's comments included, "There is always plenty of staff around," "I don't have to wait long for staff if I need them," and "I don't need my buzzer they check on you."
- Staff were visible around the home, they spent time with people, worked at their pace and didn't rush them.
- The registered manager used a dependency tool to monitor staffing levels met people's changing needs. For example, staffing levels were increased when a person needed more support.
- The provider minimised the risks for people by ensuring all new staff were thoroughly checked to ensure their suitability to work with people.

Preventing and controlling infection

- People were protected from cross infection. The service was clean and odour free and staff followed daily cleaning schedules. People and relatives' comments included; "It is very clean" and "They are always cleaning."
- Staff had completed infection control training and used protective clothing such as gloves and aprons during personal care. This helped prevent the spread of healthcare related infections.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.

- Some health risks for people were identified which related to people not always receiving their medicines in accordance with their prescription. For example, a person's blood test results at end of May 2019 highlighted they had not been receiving all their prescribed medicines.
- People and relatives said their healthcare needs were met. One person said, "They sort out my doctors and optician appointments," "All the staff are lovely, they do look after us here." Professionals said staff recognised changes in people's health, sought professional advice appropriately and followed that advice.
- The service had close working relationships with local GP's, community nurses and therapists to support people's health care needs. For example, health professionals praised staff working in the assessment unit. They said staff were good at helping people settle in quickly and worked with families to assess each person's needs, so more permanent arrangements were made to meet their care needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were fully assessed before they came to live at the service. This helped to make sure the service had staff with the right skills to provide the care each person needed.
- Care plans showed staff followed evidence based guidance in relation to people's moving and handling, nutrition, skin care and falls prevention needs.

Ensuring consent to care and treatment in line with law and guidance

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. 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.

- People were offered choices, and their consent sought, for example, before they received personal care.

One person said, "I have choices." Where people lacked capacity, mental capacity assessments were undertaken. For example, one person's care plan said, "I can make simple decisions, but am unable to make advance decisions." The care plan instructed staff and family to make best interest decisions.

- Seven people had DoLS authorisations in place and were subject to some restrictions for their safety. For example, one person's care plan showed a person needed help to wash but often refused. Staff were advised to try different approaches. Their care plan said, "Needs lots of reassurance and clarification of what is happening." Staff described approaches they used to get person's agreement for personal care. For example, that the person was more likely to accept help from older female staff than younger staff.
- Relatives and professionals told us they were consulted and involved in best interest decisions. For example, about a best interest decision to assist person with eating. However, care records lacked documentation of legal representatives/ family /advocate involvement in best interest decision-making processes.

We recommend improvements are made in recording relatives and professionals involvement in best interest decision making.

Adapting service, design and decoration to meet people's needs.

- Improvements were needed to outside enclosed garden space to make it a more safe, suitable and stimulating outside space for people living with dementia. This area had fallen into disrepair. Path areas were mossy, shrubs had become overgrown and debris from overhanging trees created slip/trip hazards. The potting shed was full of clutter. The door to this area was locked and people could currently only use this area when accompanied by staff. The registered manager said they were in process of getting quotes to undertake work to improve this area.
- The service was purpose built with wide corridors, single rooms with ensuite facilities and showers/bathrooms adapted for needs of people with physical disabilities.

Staff support: induction, training, skills and experience

- People were cared for by staff who received regular training to give them the knowledge and skills to meet their needs. Newer staff praised the induction support they received to get to know people and learn the role when they first came to work at the service. Where staff were new to care, they completed the care certificate, a nationally agreed set of standards.
- Most staff had qualifications in care, and there was a regular programme of training and updating which included moving and handling, infection control, fire safety, safeguarding and dignity training. Training methods included mostly face to face training, distance learning and competency assessments.
- Additional training was also arranged to make sure staff had the knowledge and skills to meet people's individual needs. For example, several staff had recently attended dementia training and local health professionals had done staff training on diet and nutrition, continence care and diabetes.
- Staff felt well supported in their work. They had opportunities to discuss their work, receive feedback, and identify further training and development needs through regular supervision meetings.

Supporting people to eat and drink enough to maintain a balanced diet

- People, relatives and staff praised recent improvements made in the quality and choice of food. The registered manager worked with catering staff to increase people's food choices, and make more meals from scratch using seasonal ingredients. At monthly meetings with catering staff, menus were updated to reflect people's likes, dislikes, feedback and any special dietary requirements. For example, experimenting with new dishes such as pasta and spicy food.
- People's comments included; "The food is good," and "They feed us well." Relatives said, "[Person] enjoys their food and has even put on weight," and "[Person] eats better here than they ever did at home." A staff

member said, "We will be trying different food events, a beach day, with fish and chips, Chinese food. A lot of people like Indian food. It encourages people who aren't big eaters."

- Mealtimes were an important part of the day, with staff on hand to offer any assistance needed. People were shown the meal choices on offer. One person said, "They offer me something else if I don't like it." People were offered regular hot and cold drinks and snacks throughout our visit and milkshakes were popular. This ensured people were kept nourished and hydrated.

- People at risk of poor nutrition and dehydration were closely monitored through recording their food and drink each day, and through regular weight checks.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same rating of good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People received care from staff who had positive, caring relationships with them. People seemed comfortable with staff and there was a calm, relaxed atmosphere. People said, "Everybody is friendly," "Nothing is too much trouble" and "Staff make me feel better." Relatives said, "Staff are caring," "They are always trying to help." Relatives appreciated efforts staff made to celebrate special events. One relative said, "They make a real effort for people's birthday and events like Christmas."
- Staff knew people well, about their life, family history, likes and dislikes, and what made a good day for them. They gave people plenty of time, noticed when people became upset or anxious and offered a helping hand, a gentle touch and reassurance. We saw lots of spontaneous conversations, joking and laughter. Staff had good communication skills. For example, they bent down to make eye contact with a person sitting in a chair to get their attention before speaking with them.

Respecting and promoting people's privacy, dignity and independence

- People said staff treated them with dignity and respect. They said staff ensured their privacy during personal care. For example, offering people choices between bath, shower or wash and making sure curtains were shut, for privacy. People said, "They treat you with respect," and "They listen to you and look after you."
- All staff received training on dignity and respect. A dignity champion promoted people's human rights in day to day practice. For example, they displayed posters around the home to remind staff to ensure they upheld core values of fairness, respect, equality, dignity and autonomy in people's care. One staff member said, "I treat people the way I would like to be treated."
- Before lunch, people were offered the opportunity to clean their hands with handwipes and those who needed them were offered a clothes protector in case of spills. Staff said a person tended to fall asleep during their meal, so they supported the person to eat when they were a bit more alert. If needed, staff provided equipment such as plate guards and assisted cutlery to help people eat independently.

Supporting people to express their views and be involved in making decisions about their care

- People who were able were involved in decisions made about their care. One person said, "They keep me informed of any changes and I can talk to them about anything."
- Where people needed more support with decision making, family members, or other representatives were involved. When English was not a person's first language, staff arranged for an interpreter to ensure the person and family members were fully involved in their assessment.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received personalised care which responded to their needs. People commented, "I'm happy here," "I get up when I want to get up" and "Staff join in." A relative said, "I am happy with the care mum has received." When a person asked staff for a pair of scissors to cut their nails, staff responded straightaway, they got an emery board and filed their nails for them. A health professional said, "Staff are very responsive to people's changing needs."
- Staff knew people well and care records included detailed information about each person's support needs. For example, that a person needed help with a shower but could get dressed and do their hair themselves.
- People's bedrooms were personalised with family photographs, soft furnishings and favourite objects. People tended to congregate in the large lounge/dining area on each floor, but a quieter lounge area were also available. There were pictures, photographs and things on display to interest people. For example, pictures and old photographs of the local area and of the local West Bromwich Albion football club.
- We received mixed feedback about meaningful stimulation for people. One relative commented positively on the varied range of activities including Spanish singing and dancing. Another relative said, "Staff don't stimulate [name of person] brain. They need more stimulation." They said they visited the person twice a day, and they brought in family photos and other objects to stimulate them. Each person had a social and interaction care plan with details about their interest, hobbies, relationships and community involvement.
- The service didn't have an activity co-ordinator, but recent improvements had been made in improving the variety of activities for people. For example, an activity planner showed planned activities included musical entertainment, visiting animals and hairdressing and beauty sessions. Staff organised film afternoons, games and quizzes and used music to help people engage. They told us about previous trips in the community but identified more outings as an area for improvement.
- On first day we visited, several people participated and enjoyed an exercise class. People's comments during activity included; "He gets us going" and "We have a laugh." However, at times, we saw less able people were sitting in chairs for long periods who lacked stimulation. Further improvements were needed to make activities more personalised for people, especially to meet the needs of people living with dementia and to prevent social isolation.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Each person's care plans included their individual communication needs. For example, in relation to their visual and hearing needs. Staff said written information was available in bigger print for people who needed it. A visual display board in the lounge used picture symbols to remind people of the day, date, season and weather. Signage on toilet and bathroom areas helped people identify these independently.

Improving care quality in response to complaints or concerns

- People's concerns and complaints were listened and responded to. One person said, "If there's something wrong they can put it right." People and relatives said if they were unhappy about anything, they felt happy to tell staff who addressed them.
- The provider had a complaints policy and procedure. Written information about how to raise a complaint was provided to each person and displayed on notice boards. Day to day people and families were encouraged to raise any issues.
- Three complaints had been received so far this year. Records showed the registered manager investigated these. Any lessons learnt were fed back to staff in supervision and team meetings.

End of life care and support

- People were supported to have a comfortable, dignified and pain-free death. A relative wrote, "Our sincerest gratitude to the care and kindness which you gave to our beloved [name]. Thanks also for taking care of us, we really appreciated your support."
- Staff had completed end of life care training. When a person's health declined, staff worked with local GP's, hospice and community nurses to ensure they had all the support and equipment they needed to keep the person comfortable and pain free.
- End of life care plans prompted staff to explore people's preferences and choices in relation to end of life care. Any advanced decisions people had made, for example, about resuscitation, or preferred funeral arrangements were recorded in their end of life care plan.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Some of the providers quality monitoring systems were not fully effective. This was because they did not take effective action to make the required improvements to address risks identified.
- The service carried out regular audits, which showed they were aware of risks and were making improvements in response to findings. However, audits had not identified the extent of safety issues about the unsafe administration of medicines. For example, the medicines audit involved a staff member looking at tablets, medicines bottles, trolleys and medicine administration records. There was no audit tool in use to prompt them to check standards of medicines administration met national standards. This meant shortfalls in medicines administration we found had not been identified or addressed by the provider's systems.
- Other provider audit tools seen lacked detail. For example, the environment audit was a brief tick box checklist, and the care plan audit was mainly focused on checking required documentation was in place. This meant information about the lack of detailed documentation of best interest decisions were not identified.

This is a breach of regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance

- The registered manager and their deputy were both relatively new in post. They worked well together and had shared goals. The registered manager said, "I want to make Hall Green a positive environment and the best it can be."
- They were aware of risks in medicines management, communication, and staff knowledge and had prioritised those areas for improvement within the first few months. They also identified that senior care staff needed to be more accountable for their practice and planned further training and leadership development with them.
- A quality improvement plan showed environmental improvements had been made. For example, redecorating bedrooms, replacing furniture and flooring, organising more external activities for people. Care records had been reviewed and updated, and old paperwork removed. Other improvements were underway to improve record keeping through staff training by the local authority quality assurance team.
- An operational manager did a monthly audit which included looking at staff, the environment and any complaints. The registered manager said they felt well supported by the operations manager and the chief executive of the trust.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People, relatives and professionals expressed confidence in the leadership at the home and said it was well run. People's comments included; "They listen to what you have to say," and "They help if I need anything." A relative said, "They always contact me if there are any concerns."
- Relatives praised the introduction of relatives' meetings. They appreciated being informed "honestly and openly" about any challenges at the home. For example, about staff changes and difficulties recruiting the right staff, especially at senior level.
- The service promoted a positive culture that was open and inclusive. Staff were friendly, polite, and helpful. A staff member said, "I want to give someone else's family member what I know I could give my own."
- The registered manager and their deputy worked alongside staff and acted as role models about the standards and behaviours expected. Staff comments included; "I definitely feel supported," "I've learned so much from [the registered manager], she's very helpful, understanding and great to people."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were consulted and involved in day to day decisions about the running of the home through regular meetings. A staff member said, "We have resident meetings which are done by seniors once a month. We ask for people's input re menus, activities." Suggestions included people baking cakes and doing some planting. In response to people's suggestions, a nail bar had been added to the hairdressing room. A staff member said, "It's so good for staff to spend time with people and do their hair and nails."
- Relatives meetings had recently been introduced to offer families other opportunities to give feedback. For example, families fed back that staff do not wear name badges which did not help people learn their names. Following a discussion about the safest options, a family member suggested having staff names embroidered on their uniforms. The relative was helping the registered manager to take this forward. Other improvements planned was use of noticeboards and a newsletter.
- The service had some links with their local community, although these needed further development. For example, regular visits to home from local clergy, a carol service at Christmas and a local youth team occasionally visited and sang at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Where mistakes were made, the registered manager was open and honest with people and families and outlined improvements made in response.
- Staff were encouraged to raise any concerns in confidence through a whistleblowing policy. Where any concerns about individual staff performance were identified, these were dealt with positively through training, supervision and disciplinary processes as a last resort.
- The registered manager had notified Care Quality Commission (CQC) of events which had occurred in line with their legal responsibilities. They displayed the previous CQC inspection rating in the home and on the provider's website.

Continuous learning and improving care; Working in partnership with others

- The registered manager said several families had identified communication with families as an area for improvement. For example, that messages left with individual staff were not being followed up. In response, diaries and communication books were introduced for senior staff to record and document how any messages left were followed up. Improvements were also made in daily staff handover with more detailed handover sheets introduced, so any issues were prioritised and communicated between staff.

- The registered manager had close working relationships with local health and social care professionals. They attended local professional forums and met with other registered managers within the provider group to share good practice ideas. They kept up to date with developments in practice and with regulatory changes through national good practice websites and newsletters. Learning and feedback to staff on areas for improvement was disseminated at daily handover and through staff training, supervision and team meetings.

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 17 HSCA RA Regulations 2014 Good governance</p> <p>Some of the providers quality monitoring systems were not fully effective. This was because they did not take effective action to make the required improvements to address risks identified.</p> <p>This is a breach of regulation 17, Good governance. Regulation 17 (1)(2)(a)(b)</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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>People were at increased risk because medicines were not managed safely and in accordance with best practice guidelines. People did not consistently receive medicines prescribed for them, and staff lacked detailed instructions about how to administer medicines.</p> <p>This is a breach of regulation 12, Safe care and treatment. Regulation 12 (2) (g).</p>

The enforcement action we took:

Served a warning notice