Beaumont Nursing Home Limited

Downlands

Inspection report

96 The Drive
Hove
East Sussex
BN3 6GP

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 16 March 2016 and was unannounced.

Downlands provides nursing and personal care and support for up to 23 older people or people with a physical disability. The service offers long term and respite care. At the time of inspection there were 19 people living at the service. People were mostly older with complex needs or physical frailty requiring personal care and nursing support with all activities of daily living. Accommodation is provided over three floors, in single rooms with en-suite facilities to all bedrooms. The service is located on a main road in a residential area, close to transport links to local shops, the seafront and the city centre. The provider, Beaumont Nursing Home Limited, has another service in Northamptonshire.

The service had two registered managers. This is because one of the registered managers had stopped managing the service but had not submitted an application to CQC to cancel their registration. The current registered manager in post was present throughout the inspection. 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. Downlands registered with CQC on 3 February 2015 and has not been previously inspected.

Individual preferences were not always respected for example people were not supported to get up or go to bed at their preferred time. People told us that the food was good but they were not offered a choice at meal times. On the day of inspection everyone was served the same menu item even though two people told us they did not like this menu item. There was a four week menu in place but it was not displayed and suitable alternatives were not routinely offered to people. This meant that care was not always person centred as people's preferences were not respected.

Staff did not always act in accordance with the Mental Capacity Act (2005) (MCA). The provisions of the MCA are used to protect people who might not be able to make informed decisions on their own about the support they receive. One person who was thought to lack mental capacity did not have a mental capacity assessment or sufficient detail in their care plan to support a decision made on their behalf to use bed rails and we identified this as an area that needs improvement. Staff were aware of those people with a DoLs authorisation the details of which were stored alongside the care plan in their individual records.

There were regular Infection Control and Medication Audits which demonstrated improvements but other systems to assure quality and drive improvements to the service were limited or informal. Relatives and residents surveys had taken place but people and relatives told us they did not feel confident to express their concerns or preferences and we have identified this as an area that needs improvement.

Staff understood their responsibilities in relation to keeping people safe from harm and there were sufficient staff on duty to meet people's needs.

The management of medicines was safe. People received their medicines correctly and on time. A person said, "I can get pain relief when I need it, I will ask staff." There was clear guidance and information provided to staff to support them to administer medicines safely.

Individual risk assessments were in place to ensure that people's health needs were appropriately managed and these were updated regularly and in accordance with any guidance from health care professionals. Planned care accurately reflected care delivered. There was a system in place to monitor accidents and incidents. The environment and equipment was managed through regular checks and servicing and there were emergency plans in place for the service and individuals.

People with difficulties eating and drinking for health reasons were identified and supported by timely referral to health professionals such as Speech and Language Therapists. Any recommendations made by health care professionals were detailed in individual care plans and followed by staff.

There was a training plan in place and staff said they felt supported. Staff told us that they received regular supervisions, competency checks and observed practice. The nursing staff we spoke to were knowledgeable and experienced in the care of people with complex nursing needs.

Relatives described staff as, "Kind and friendly." One person said, "Yes, they are nice to me, they (staff) help me." Staff were genuinely interested in people and were caring and kind in their interactions with them. Staff took time to encourage people to join in activities that they knew they would enjoy or to make it possible for people to attend an event despite their limitations. Staff took care to maintain people's privacy and dignity whilst supporting them.

There was an activity plan in place and activities were planned according to the interests and preferences of people living at the service. There were activities going on throughout the day ranging from individual chats to group activities. People were supported and encouraged to attend those activities they enjoyed and staff made an effort to ensure that those who preferred not to join in group activity were not isolated.

There was a complaints process in place and all complaints had been responded to appropriately and within a reasonable time frame.

The registered manager and other staff were active in the local health care community. They met regularly with local care home managers and activity staff to keep up to date and share best practice. The provider also worked with other agencies such as the Alzheimer's Society and the Blind Society to support people who were at risk of social isolation.

We identified a breach of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their responsibilities in relation to keeping people safe from harm and there were sufficient staff employed to meet the needs of people using the service. The registered manager proactively managed recruitment ahead of vacancies to maintain staff numbers and minimise the use of agency staff.

Individual risk assessments were up to date and gave clear guidance to staff on how to support people to minimise any identified risks.

There was a system in place to record, monitor and review accidents and incidents and actions were taken to reduce the risk of recurrence.

Medicines were administered sensitively and safely in accordance with prescribing instructions.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a training plan in place and staff were supported through supervision, observed practice and competency checks.

Staff had not always followed the legislative requirements of the Mental Capacity Act 2005 (MCA).

People were supported to maintain adequate nutrition and hydration.

People were supported to maintain good health. Health needs were anticipated with appropriate and timely referral to health care professionals.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People's privacy and dignity were respected.

Communication between staff and people was relaxed, appropriate and respectful.

Relatives and visitors were able to visit at any time and were made welcome.

Is the service responsive?

Requires Improvement

The service was not responsive

Individual preferences were not always respected and people were not always supported to make choices.

People were not offered sufficient choice at mealtimes.

People were engaged in meaningful activities as individuals and as a group. There was an activity plan in place that was developed around the interests of the people living at the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

People and their relatives were not consistently encouraged to give feedback or share their experiences of the service.

There were systems in place to monitor infection control and medication management which demonstrated improvement, However, other quality assurance measures were not consistently documented or acted upon.

The registered manager and staff were active in the local healthcare community and had used their links to secure training and resources for the service.

Downlands

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 was 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 5 April 2016 and was unannounced. The inspection team consisted of three inspectors and one inspection manager. The service registered with CQC on 3 February 2015 and had not previously been inspected.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included notifications. Notifications are changes, events or incidents that the service must inform us about. We also contacted stakeholders, including health and social care professionals involved in the service for their feedback.

We spoke with six people, four relatives and visitors, eight members of staff and the registered manager. During the inspection we observed the support that people received in the lounge and dining areas and where invited, in their individual rooms. We took time to observe how people and staff interacted at lunch time and during an activity.

We reviewed four staff files, 11 medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, quality monitoring documentation, training records and surveys undertaken by the service. We also looked at the menu and activity plans.

We looked at seven sets of personal records. These included care plans, risk assessments, and daily notes.

Good

Is the service safe?

Our findings

People told us they felt safe and a relative told us, "She is absolutely safe." People said they felt secure they said that they felt, "looked after" and that the staff knew, "what was what."

There was a safeguarding adults at risk policy and a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. Safeguarding procedures and contact details were on display in staff areas and staff had received safeguarding training. Staff had a clear understanding of their responsibilities around identifying poor practice and recognising the signs of abuse and knew how to report their concerns.

People received their medicines safely. Medicines were stored safely and appropriately and people were receiving their medications as they were prescribed. Medicines were administered by nurses and we observed people being given their medicines. The nurse sought consent before administering medication; they asked one person, "Can I give you the chewy tablet before you go to lunch?" Another person was eating their lunch so the nurse made a note to return with their medicines when they had finished. 'As required' medications are medicines that are meant to be taken occasionally when there is a specific need, for example, for pain. Three people were offered 'as required' medicine. One of these people had communication difficulties so the nurse assessed whether they required pain relief using a pain scale. The medication records contained clear guidance to staff for the administration of medicines with variable dosages and protocols were in place for 'as required' and medicines to be crushed prior to administration. A nurse told us that they had received medication training and a competency check to ensure that they were competent to give medicines and there was a medication policy and monthly audit system in place to check that people received their medicine correctly.

People had individual risk assessments in place to assess their risk of malnutrition, pressure damage and mobility which included risk of falls and manual handling considerations. Where people had specific health needs there was a detailed risk assessment and care planning to support these needs and minimise risk. Risk assessments and care plans were subject to monthly review and staff had a good understanding of the needs of people. Staff followed the guidance set out in care plans when delivering care. For example one individual plan noted that a person required the support of two members of staff to mobilise. The risk assessment and care plan detailed the equipment that should be used to assist them and we observed that two members of staff assisted the person to move safely from their bed into a wheelchair using the equipment specified.

There was a system in place for monitoring accidents and incidents with monthly reviews to identify trends and check appropriate actions had been taken. The registered manager had oversight and knowledge of all recorded accidents and incidents and there was evidence that risks were being managed safely and appropriately.

The environment was managed safely. The provider employed a dedicated maintenance person and day-to-day repairs were attended to within a reasonable time scale. There were routine safety checks of equipment

to ensure that they remained safe for use. There was an emergency plan in place and each person had a Person Emergency Evacuation Plan (PEEP) detailing how they should be assisted to evacuate the building or an area of the building in the event of a fire.

Staff rotas confirmed that there was sufficient numbers of nurses and care staff planned to support the needs of people. The registered manager anticipated staff shortfalls and was recruiting in advance of known vacancies to ensure that there were sufficient care and nursing staff recruited to maintain safe staffing levels and avoid the use of agency staff. The registered manager confirmed that staffing levels were identified by the number of people using the service, however there was some flexibility should people's need arise then they were able to increase staffing accordingly. People told us that their call bells were answered promptly. One person said, "I've got the bell, I can always ring." Another person told us, they are usually very good at answering." Call bells were placed in easy reach of people. A staff member explained, "We always do this to make sure that they can call us if they need to."

Staff had been recruited through a recruitment process that ensured they were safe to work with vulnerable people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Checks were also undertaken with the Nursing and Midwifery Council (NMC) to confirm that nurses were registered with them and were able to practice.

All areas viewed were clean and any malodours were managed quickly and effectively. The registered manager had received training as an infection control champion and had shared her knowledge with staff. People told us that their rooms were cleaned every day and the rota showed that there was a person employed to clean the service Monday to Saturday. We saw regular infection control audits with clear action plans in place. For staff working in the laundry these action plans were translated into their first language for ease of understanding. We observed staff using good infection control practices in the use of personal protective clothing to help prevent the spread of any cross infection.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that they were cared for by skilled and experienced staff and we observed that staff supported people knowledgeably with their health and wellbeing and followed guidance from health and social care professionals. However we found that not all practices enabled people to make decisions about their own care and support.

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 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. Staff had received training and demonstrated a basic understanding of the principles of the MCA. They were aware of those people with a DoLs authorisation the details of which were stored alongside the care plan in their individual records.

A family member had signed the consent for the use of bed rails for one person but there was no mental capacity assessment in place. This meant that a restriction had been placed on the person without their consent and without due consideration of the principles of the MCA and this was identified as an area that needs improvement to help ensure that people's rights to make decisions are always being protected.

There was a training plan in place and the registered manager had actively sought out opportunities to develop staff. For example, she had applied and obtained a programme of support from the Brighton & Hove Dementia In Reach Team. The Dementia In Reach Team works with care and nursing homes to improve the quality of life for people with dementia, which can include staff training in dementia awareness, person centred care and meaningful activities. The registered manager told us that she attends regular meetings for local managers of services for older people in order to keep up to date and share best practice.

The registered manager and staff told us that regular supervision, observed practice and medication competency checks took place. One member of staff told us, "The registered manager is always everywhere she watches us and then tells us how we can do better." Staff told us they felt supported and they were clear about their roles and responsibilities. The nurses we spoke to were knowledgeable and experienced in the care of older people and the care of people with complex needs. The registered manager was also a nurse and regularly worked rostered nursing shifts alongside staff and a nurse described how together they regularly reviewed care and support for people.

People's health and wellbeing were monitored and where required they were supported to access routine medical support, for example, from health care professionals such as doctors, opticians and chiropodists.

Referrals made to specialist health services, were timely and appropriate and any recommendations had been incorporated into people's care plans. For example one person had a wound that was difficult to heal and a referral was made to the Tissue Viability Nurse (TVN). The recommendations of the TVN were followed and the wound had significantly improved. Another person was supported by the community nursing team for a pressure wound sustained away from the service. Their recommendations were followed and the pressure wound healed.

Malnutrition Universal Screening Tool (MUST) was used to monitor people's nourishment and weight. MUST is a five-step screening tool that identifies adults who are malnourished or at risk of malnutrition. Where people had been identified as at risk of malnutrition or hydration guidelines had been put in place for staff to follow. People at risk's weights showed that prompt action had been taken where any unplanned weight loss had occurred.

People said they enjoyed the food and told us that it was good. One person said, "Food is nice…I do like soup and I get it most nights." We observed that the lunch smelt appetising, was well presented and served hot. People were supported to have sufficient to eat and drink and to maintain their weight. Individual records showed detailed guidance for staff on how to support people to eat and drink and staff were proactive in identifying loss of appetite or difficulties eating. For example staff noticed that one person was spitting out her food. The person was immediately supported with a fortified, fork mashable diet, a risk assessment was completed and a referral was made to a Speech and Language Therapist (SALT). A SALT will assess a person's ability to swallow and make recommendations on how to support that person to eat and drink. The SALT recommended that the person should continue with a fortified, fork mashable diet and the person's care plan was updated to include this. A review of monthly weights showed that despite difficulties eating the person had maintained their weight throughout this period.

Good

Is the service caring?

Our findings

People told us were happy and that they felt cared for. One person said, "(Staff) are good to me…see little things that need doing." We saw staff greeting people individually and in accordance with their preferred form of address. We heard a member of staff sharing a joke with a person regarding how many sugars they had in their tea and friendly conversation between a staff member and people sitting in the lounge area. A member of staff complimented a person on their new haircut and another engaged in friendly banter with people wherever they went.

We heard staff asking people what they would like and if they were comfortable. We felt that staff were genuinely interested in how people were feeling. One member of staff asked a person, "Is the light too bright? Is it in your face?" Another asked a person, "Can you manage? Do you need anything?" Staff clearly understood people's social histories; one member of staff spoke knowledgeably to a person about the music they liked and to another about members of their family.

One member of staff said, "The best thing about the home is that the staff care about the residents and get to know them individually by building a relationship with them." We observed staff encouraging people to come to the lounge in the afternoon as there was a jazz singer. One of these people said she did not like group activities but later on we saw them smiling and dancing with staff in the lounge. This demonstrated that staff knew the person well and that they took the time to encourage them to join in with an activity that they knew they may enjoy.

We heard a discussion between a nurse and a person regarding a change in their pain medication. The nurse explained that their current medication made them very sleepy. They described the new pain regime to the person and checked their understanding frequently. The nurse told the person what would happen if the proposed pain medication was not effective and asked them to let the staff know, "day or night," if they are in pain. Once the nurse had established that the person fully understood the change they sought their verbal consent to the change in medication.

Some people had chosen to eat their lunch in their bedroom. We observed a member of staff supporting a person with their meal. The member of staff brought their meal to them and explained what it was. They sat at the same level as the person to assist then and spoke in a kind and gentle manner. The member of staff allowed the person to eat at their own pace, waiting until they were ready before presenting the next mouthful and offering a choice of meat or vegetable from the plate.

Staff described a number of ways in which they promoted peoples independence, this included encouraging people to do as much for themselves as they were able.

Some staff had received training in dignity and empowerment and there was a poster for care staff on how to support people with dignity and respect displayed in a staff area. Staff gave personal care in the privacy of people's own bedrooms and placed a sign on the door which said, 'Engaged! Please knock and wait for response before entering. Care in progress.' When a person became unwell in a communal area staff used a

portable screen to protect their dignity. People were able to choose the gender of staff to support them with personal care and staff knew who these people were and what their preference was. A person told us, "I don't mind if I have male or female staff, I was asked but I'm ok with it."

There were regular visitors in the home throughout the day and people told us that their families visited regularly. One person and their relative were seen potting plants in the garden and another person was being visited by a friend. This visitor told us that they visit regularly and are, "Always made to feel welcome by being offered cups of tea…staff are always very friendly."

Requires Improvement

Is the service responsive?

Our findings

Care was not person centred. People told us they were not making day to day decisions for themselves such as what time to get up in the morning or what to have for lunch. One person told us, "I don't know what is for lunch they just bring it." Another told us that her bedtime was not too late but it, "Depends on how busy they are."

During the inspection we saw that one person was calling out for assistance at 9.40am. This person pressed their call bell at 9.55am and a member of staff attended. The member of staff turned off the call bell and told them that they would come back. The person continued to call out, "I would like to get up please is somebody coming to get me up please, "and as time passed they became increasingly distressed and shouted, "Hello I feel sick I will have to stay in bed all day at this rate." They told us that they liked to go to bed at 6.00pm and get up at 8.00am. Their care plan stated that they could become anxious and disorientated at night and that staff should offer reassurance. Notes from the previous night did not indicate any reason why the person should not be assisted at their usual time. The person said to us that they had, "never waited this long before to get up don't know what is happening." At 10.15 another member of staff entered the room to tell the person that staff would be helping the person in the room next door first. Staff told us the delay was due to a shortage in moving and handling equipment. The person was assisted to get up at 10.40am. This was more than two and a half hours past their preferred time to get up with no clear explanation or reassurance from staff who did not respond appropriately to this person's needs or respect their preference to get up at 8.00am.

At lunchtime everyone was given the same lunch. Two people said that they did not like chicken, one person said, "They gave me chicken, but I don't like chicken." We saw that those people did not eat their meals but no alternative was offered. People and their relatives told us that they were not offered a choice of meal. One relative explained, "There is never a choice of food, always the same, she just has to put up with it," and another told us, "There is only one meal choice." The chef told us people were offered a choice of two meals but was unable to remember what the second choice was that day. We were told that people were asked what they wanted the day before and we were shown a form detailing these choices. The form was marked to indicate that everyone had chosen the same meal option for lunch and 16 people had opted for the same meal at supper time. There was a four week menu plan but this was not displayed where people could see it. Omelettes or sandwiches were offered as alternatives to the main menu. People's dietary requirements were noted on the form recording daily menu choices and were saw that these were adhered to. There was no system in place to obtain feedback from people in respect of menu choices and the quality of the food but lack of choice of food was raised as a concern by two relatives in a survey undertaken in February 2016. This meant that people's food preferences were not being respected.

This meant that people did not receive care and treatment which reflected their preferences or wishes which is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff followed the guidance set out in care plans when delivering care, for example one individual plan noted that a person had communication difficulties. The care plan stated that their hearing aid should

always be in place and that their glasses should be clean. The plan also suggested that staff lower the volume of the television and speak clearly in short sentences. We observed that this person had their hearing aid in place and their glasses were clean. A member of staff entered this person's room and turned the television down whilst they spoke to them. They spoke clearly, in short sentences and regularly checked that the person had understood. The member of staff turned the volume of the television back up again once their conversation had finished.

A residents survey had been undertaken in February 2016, with the support of the activities coordinator and the registered manager was in the process of reviewing the results.

The complaints process was displayed in reception. The registered manager had fully investigated and resolved all complaints in an appropriate and timely manner and there were no outstanding concerns. The registered manager had received one compliment in this period from the relative of a person who had a period of respite care that complimented the service on its' 'happy crowd.'

Activities were tailored to meet the needs of individual people and there were sufficient varied activities provided for people to enjoy. The provider had employed a dedicated activities coordinator to plan and oversee activities There was an activity plan on display in the lounge and in people's rooms. An activity was planned for each weekday. The activities coordinator explained that the plan was developed around peoples preferences. For example one person liked Irish music so an Irish entertainer was booked. Another had a cuckoo clock so a group met regularly to track cuckoos across the world and this was very popular. A visitor to the home said, "The best thing about the place is the activities. They seem to be doing things three times a day. They are either making things or talking; she (her friend) seems to really enjoy them." One person told us, "I think there is a singer today, I'm not bored." The activities coordinator told us that they regularly visited those who were unable to join in group activities or those who preferred not to socialise with other people living at the service. They explained how they had built relationships with them and their families and kept them up to date with what was going on at the service.

There were activities going on throughout the day ranging from individual chats to group activities. We observed the activities coordinator spending time with people individually. They clearly knew people well and we saw that the people responded positively to their presence. One person said, "I sometimes get bored, but they have a lady (the activities coordinator) who comes in to me now to sit with me." A group of people were observed in the lounge with the activities coordinator. Music was playing and people were discussing their favourite songs. Another member of staff entered the lounge and began singing and dancing to the music and there was much laughter. The group decided they also wanted to sing along and decided on a song that they all wanted to sing.

We noticed staff encouraged people to come to the lounge after lunch to listen to a jazz singer. One person wanted to attend but was not able to sit for long periods. The nurse explained that in order to accommodate their needs this person would take their lunch in the dining room. "At the last minute," so that she could stay on for the entertainer. We saw this person and six other people enjoying listening to the jazz singer in the lounge after lunch.

The activities coordinator has regularly attended the Brighton and Hove Activity Workers Forum run by the Dementia Care Home In Reach Team. The forum meets monthly to share resources and discuss best practice to support people living in care homes with meaningful activity. They spoke about how inspiring this group had been in helping them to develop a range of activities at the service.

Requires Improvement

Is the service well-led?

Our findings

The service had two registered managers. This is because one of the registered managers had stopped managing the service but had not cancelled their registration with CQC. The registered manager in post was present throughout the inspection.

The registered manager had a thorough knowledge of the service but there was a limited system in place to monitor the quality and effectiveness of the service. Actions identified through quality assurance systems were not always followed through. For example, a relatives survey conducted in February 2016 identified a lack of meal choices as a concern but there was no action plan in place to address this and people continued to experience a lack of choice of food. In a relatives survey in 2015 concerns had been raised regarding the tired décor and furnishings in the lounge and this had been refurbished. Regular infection control and medication audits followed a formal process of feedback and action planning and these were effective in driving improvements to the service.

We received feedback and observed that staff were not always respectful when speaking about people. They sometime referred to people by their room number when speaking about them to other staff or described people in terms of the support they needed. For example. 'feeder,' to describe a person needing support to eat and drink. The registered manager was aware of this issue and staff had received dignity and empowerment training in an effort to address the problem. However, the issue was not included on staff meeting agendas or formally documented and it was noted that staff continued to refer to people by room number or by the support they required.

A relative told us that they felt, The manager is not proactive in approaching us, any issues, we need to approach her." In addition to this people and relatives did not feel that the registered manager was accessible. One person told us that, "The manager talks to my daughter, not me," And a relative commented that, "The manager is not visible and stays in her office." Relatives told us that they did not always feel comfortable raising a complaint as they felt it might impact on the care of their family member. One relative said, I would be worried about making a complaint and others have said this to me too. I would worry it would reflect in the care, so we hold back."

We have therefore identified a lack of opportunities for feedback and formal follow up on feedback as areas that needs improvement to help ensure the continuous improvement of the quality of the service.

The registered manager ran the service with the help of a team of nurses. The registered manager was a nurse and also worked direct shifts which enabled her to understand people's needs on a day to day basis. Nurses described a collaborative approach between the nursing team and the registered manager and told us that they regularly consulted with the registered manager for guidance. A member of staff said, "She is very good and cares about the residents here." Another member of staff said that, "It's a wonderful team to work for and the staff on the whole are happy." The staff we spoke to were positive and enthusiastic about the service.

The provider had good connections with outside agencies and the registered manager and activities coordinator attended local health and social care forums in order to keep up to date and share best practice. Members of The Alzheimer's Society and the Blind Society were supporting people in the home with regular visits and the registered manager had approached the Dementia In Reach Team for training and support for staff regarding dementia and person centred care.

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 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users had not always been provided to reflect their preferences. Regulation 9 (1)(c)