Integra Care Management Limited

374-376 Winchester Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 13 July 2016. The inspection was unannounced. 374 – 376 Winchester Road provides accommodation and support for up to eight people who have a learning disability or autism. There were six people living at the home when we carried out the inspection.

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

We found people's safety was compromised in some areas. People's medicines were not stored safely and keys for the medicine cabinet were kept where they could be accessed by people and staff who were not authorised to handle medicines. There was no clear guidance for staff on when to administer 'as required' medicines.

Environmental risks were not managed effectively; window locks were not secure in the upstairs bedrooms which put people at risk. Not all fire extinguishers were accessible in the event of a fire. Cleaning chemicals that required storing in a locked cupboard could be access by people using the service.

The home was not following guidance recommended by the Department of Health on infection control. One person had been using a mattress which was very stained and dirty.

The two shared bathrooms were not homely or pleasant to use and were unsuitable for people living at the home. Other areas of the home were worn and in need of updating.

People's care plans provided information to guide staff. However, we found some contained inaccuracies and missing information. There was concerns regarding one person when they put themselves or others at risk. Their plan of care did not offer much information to support them and the person living at the home.

The quality and monitoring system was not effective in order to ensure necessary changes were implemented. These had not picked up the issues relating to the quality and safety of the service provided.

There were enough staff to meet people's needs. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse.

Staff received regular one to one sessions of supervision to discuss areas of development. They completed a range of training and felt it supported them in their job role. New staff completed an appropriate induction programme before being permitted to work unsupervised.

Staff sought consent from people before providing care and support. The ability of people to make decisions

was assessed in line with legal requirements to ensure their rights were protected and their liberty was not restricted unlawfully. Decisions were taken in the best interests of people.

People received varied meals including a choice of fresh food and drinks. Staff were aware of people's likes and dislikes and offered alternatives if people did not want the menu choice of the day. People were supported to access healthcare services.

People were cared for with kindness, compassion and sensitivity. Care plans provided comprehensive information about how people wished to receive care and support. This helped ensure people received personalised care in a way that met their individual needs.

People were supported and encouraged to make choices and had access to a wide range of activities. The provider sought feedback through the use of quality assurance questionnaires and is going to use the results to improve the service.

A complaints procedure was in place. There were appropriate management arrangements in place and staff felt supported.

We identified breaches of regulations of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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?

Inadequate

The service was not safe.

Medicines were not stored securely. There was no clear guidance for staff on when to administer 'as required' medicines.

The home was not clean and one person was using a mattress that was not clean and hygienic.

Individual risks to people were not always managed effectively. The two shared bathrooms were not homely or pleasant to use and presented a risk to people.

There were enough staff to meet people's essential needs and recruitment practices were safe.

Staff knew how to identify, prevent and report abuse and people's money was managed safely.

Is the service effective?

Good

The service was effective.

Staff told us they felt supported and received sessions of supervision and completed training relevant for their role.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights. People were supported to access health professionals and treatments.

Is the service caring?

Good

The service was caring.

People and their families felt staff treated them with kindness and compassion.

People's privacy was protected and staff treated them with dignity and respect. People were supported to be independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans provided comprehensive information to guide staff. However, some care plans contained inaccuracies and missing information.

There was concerns regarding one person's behaviour but their plan of care did not offer much information to support them and the person living at the home.

People had access to a range of activities which they could choose to attend.

The home had a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality and monitoring system was not effective in order to ensure necessary changes were implemented.

Staff received regular staff meetings and were valued through an awards scheme.

The provider sent notifications as required by CQC of all significant events.

374-376 Winchester Road

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 the 13 July 2016 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with one person living at the home and two family members. Following our inspection, we received feedback from two health care professionals. We also spoke with the registered manager, the new manager, the deputy manager and five care staff members. We looked at care plans and associated records for four people, five staff recruitment files, accidents and incidents records, policies and procedures, minutes of staff meetings and quality assurance records. We observed people being supported in the communal areas of the home.

We previously inspected the home in June 2013 when no concerns were found.

Inadequate

Is the service safe?

Our findings

Medicines were not stored securely. Medicines were stored in locked cupboards in a small walk-in cupboard off the care staff office. The door to the walk in cupboard did not lock. Staff told us this had been broken for several weeks. The keys to the locked medicines cupboards were kept where they could be accessed by staff and people and staff who were not authorised to handle medicines. We checked and these opened the medicines cupboards giving access to all medicines stored therein. There were also no facilities for the safe storage of medicines which were required to be kept at cooler temperatures i.e. in a fridge. Senior staff told us these would be put in a plastic tub in the fridge in the home's main kitchen. We saw the door to the kitchen was not locked and people could and did access this area. There was a system in place to record the temperature of the medicines storage area but records showed this was not always recorded every day.

Medicines had not been given as prescribed. We checked stocks of some medicines and found that more had been signed for as having been given than had been received into the home. Senior staff, including the registered manager and new manager, agreed that staff must have signed for medicines which they had not administered. Formal medicines audits were not being completed. When new stocks of medicines were received each month staff told us these were checked and counted in but otherwise there were no medicines audits. This meant people might not be receiving their prescribed medicines as required.

There was no clear guidance for staff as to when to give 'as required' medicines including sedative medicines and pain relief. For example, one person was prescribed four different pain relief medicines; however, there were no guidelines for staff as to when or which they should administer. A staff member providing individual support asked the senior staff member for some pain relief for a person. They said the person was making a noise which may be related to pain. However another staff member told us the person also made a similar noise when they were happy. The senior staff member checked the person's medication administration records (MARs) and said that it had been less than two hours since they had previously received a similar medicine so they could not have it. They later realised that the person had not had the medicines earlier and so they may have been in pain. This meant systems were not clear and people might be in pain, and not be able to receive effective relief. There was a system to record as required medicines given including the reason why given and time of administration.

Where changes or additions had been made to MARs these had been handwritten and had not been signed by any member of staff. It was therefore not possible to determine which staff member had made the additions. There was also no evidence to show that the entry had been checked by a second member of staff. This is contrary to good practice guidance issued by the National Institute for Health and Clinical Excellence (NICE). Information about people's allergies to medicines were not always correctly recorded on their MARs. This placed them at risk of receiving medicines they should not have and which may make them unwell. When medicines had been discontinued these remained on the MARs, in one instance for several months. Staff said the pharmacist had not removed them; however, staff could have crossed through these and recorded that these had been discontinued. Systems to ensure prescribed topical creams were not used beyond their safe to use date after opening were not in place. There were no dates of opening on any prescribed topical creams meaning staff would not know when they would need to be discarded.

Staff administering medicines had received appropriate training and we were told they were now to do a competency assessment every six months.

The failure of the provider to have an effective system in place to ensure the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was not clean or hygienic. In the garden we saw a mattress which was stained and dirty in a number of places. This had been placed by staff against a fence along with a torn plastic mattress cover. We showed this to the registered manager who agreed that it would not have got into this condition in one night as there was staining on both sides of the mattress and the staining appeared to be of different ages. Senior staff could not explain why the mattress was there and agreed that the mattress was unsuitable for continued use. We identified that the mattress had been removed from the bed of a person that morning. However, staff had not informed the managers of the need to urgently get a new mattress for the coming night.

The home had an infection control lead. Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. We found these measures had not been taken in relation to the environment and staff practices. The code of practice also requires providers to complete an annual statement detailing what policies and infection control risk assessments are in place, and any staff training or outbreaks of infection that have occurred, as well as carrying out audits and spot checks on cleaning and staff practices. The provider had not completed any audits, risk assessments or an annual statement as required by the code. Consequently the provider could not demonstrate that the risks of people acquiring getting an infection had been identified and were being managed effectively. We saw a cleaning schedule for staff to follow but this had not been completed to show the cleaning had been completed. However staff told us they found it hard having to complete cleaning tasks as part of their role, and just fitted these in when time was available. A staff member told us, "We use to have a cleaner employed at the home with the old provider, but when the new one took over we were informed that we had to do the cleaning and it's impossible to do now our hours have been cut

The failure to follow infection control procedures was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments covered personal care and support for when people went out in the community and participated in social and leisure interests. These were individual and relevant to the person concerned but were not always followed by staff. For example, risk assessments in care plans stated that hazardous substances should be locked away. In all areas of the home including bathrooms, bedrooms, communal rooms we found substances hazardous to health were accessible to people. These were not secure and placed people at risk.

We also found risk assessments relating to the environment were inaccurate. For example, on one person's file it stated that they lived in a first floor bedroom. Staff informed us that this person had never had a first floor bedroom. Environment risk assessments had not ensured the safety of the environment as they were not being followed by staff and contained the wrong information. Window restrictors on the first floor were not suitable as they could easily be lifted off the catch by people and the windows then opened wide. This put people at risk of falling through them. We spoke to the registered manager about our concerns with window restrictors who informed us they would ensure maintenance staff visited the next day to secure the windows so they were safe for people living at the home.

Fire extinguishers around the home were kept in locked cases; however, not all had a key nearby meaning that in an emergency staff would not have been able to access the extinguishers. An electric fuse box cupboard contained potentially flammable items, posing a fire risk. The provider's procedures required fire alarms and doors to tested weekly and emergency lighting to be checked monthly. However records showed these were last recorded as being tested on the 25 April 2016 seven weeks before the inspection.

People had their own bedrooms and had access to a lounge, dining room, kitchen and garden. This gave people the option of where they wanted to spend their time. However, the home had two shared bathrooms, neither of which were homely or pleasant to use; they were also unsuitable for the people living at the home. One had a walk in bath, although staff said this was not required by people. They told us that they could only fill the bath to about five centimetres as after that it leaked water onto the floor creating a slip hazard for staff and people. The other bathroom had a shower over the bath, but no shower curtain or screen. Staff told us they got very wet, as did the floor, again creating a slip hazard to staff and people. Some people had ensuite facilities in their bedrooms. A health professional told us, "There could be some more investment into the home to make it more homely."

The home did not have an appropriate system to assess and analyse accidents and incidents across the home and lessons were therefore not learnt from them. Staff were not recording or reporting to senior staff all accidents and incidents that occurred meaning they could not be reviewed and any trends or patterns identified. This also prevented any action being taken to reduce the risk of repeat incidents. For example, one person was seen with a blue plaster on their arm. We asked senior staff about this and they were unaware of the person's injury and an accident form had not been completed. The person said they had cut it on a sharp edge on a door. Had this been reported, the sharp edge could have been repaired to prevent a future accident.

Shortly before our inspection, one person was involved in an incident which required medical treatment. The accident form and related records in the person's care file were incomplete. There was no information to help staff understand why the incident had occurred and there was a lack of detail as to exactly what had happened. The incident form described the person's behaviour as "aggression"; however, there was no information about what had triggered this or what had actually happened. Staff told us there were "lots of incidents" relating to one person; however, we could only find one incident report and no other records of incidents elsewhere in the persons records. A staff member said the decision to record incidents depended on which senior staff member was on duty. They told us about an incident recently when they had not been on duty but had been requested to provide assistance to two staff when one person had become agitated when out in the car. We asked for the incident record for this event, which must have been significant if there was a need to request an off duty staff member to provide support, but none was available in either the persons file or in accident records.

The failure to ensure individual risks to people were managed effectively was a breach of Regulation 12 Health and Social Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at 374-376 Winchester Road. One person said, "I feel safe, I feel okay."

Personal emergency evacuation plans were seen in each person's care file. Staff had supported people to learn what to do if there was an emergency. People had been taught that in the event of an emergency they must go outside and stand on a red mat. This would help ensure that in an emergency people would act appropriately for their own safety. One staff member told us, "Fire training is once a month. We had a fire evacuation last month; we have them every once in a while."

Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. The manager described the action they would take should a safeguarding concern be brought to their attention. Systems to manage people's personal finances were in place and helped ensure people were not put at risk of financial abuse. One staff member told us, "I have received safeguarding training and if I had any concerns I would report it to a senior member of staff. If they didn't do anything I would go higher."

There were enough staff to meet people's needs and keep them safe. A family member told us, "Seems to be enough staff, they do have a high turnover of staff but staff are good." A health professional told us they were always attended to promptly when they visited the home. Another health professional said, "Anything I have asked for has been readily available."

Robust recruitment processes were followed that meant staff were checked for suitability before being employed in the home. Staff records included an application form and a record of their interview, two written references and a check with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working at the home.

Good

Is the service effective?

Our findings

People who used the service appeared happy with the care and support they received. One person told us, "Food is very nice; I had fish and chips last night. I can have a choice of whatever I want." A family member said, "[the home] a very good home; we are very happy." Another family member told us, "[My relative's] personal care is brilliant; staff look after him well and staff in the main are very helpful."

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to 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. Where people had been assessed as lacking capacity, best interest decisions about their care had been made and documented, following consultation with family members and other professionals, where relevant.

People's consent to care and treatment was sought in line with legislation. Staff were clear about the need to seek verbal consent before providing care or support and we heard them doing this throughout our inspection.

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 was being met. DoLS applications were being processed by the local authority for five people. Staff were aware of how to keep people safe and protect their rights.

Staff told us they completed the provider's mandatory training, including safeguarding, medicines management and infection control. Staff had also received additional training relating to learning disabilities and understanding autism. However, they said additional training, specific to the needs of one person living at the home, was required to support this person when they became agitated and distressed. The provider had arranged some specific training to support this person which was due the week following the inspection. Agency staff who frequently worked with this person were also to be included in the training.

New staff received induction training which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. One staff member said, "Training is very good, classroom based and e-learning. I got a lot of information in my first few weeks."

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One staff member told us, "I had my last supervision about three months ago, and am due another one soon; they are helpful as we can talk about any problems and what we can do to improve it for

residents." Another staff member said, "Supervisions are very helpful; I am able to put my view across." We saw records that supervisions were taking place with the new manager. The new manager told us, "I realised staff didn't have many supervisions on file so even though I have only been here two weeks, I have been working hard to see everyone for supervision then I will work on completing appraisals for all staff."

People were offered nutritious meals and a variety of drinks to suit their individual preferences and people told us they liked the food. One family member said, "[person's name] likes all the food." Alternative meals were offered if people did not like the menu of the day. One staff member told us, "The menu is decided weekly, we use a picture menu so people can choose." We saw one person was able to make a drink independently and regularly went into the kitchen to make a hot drink. Care records contained information about people's dietary needs, their likes and dislikes.

People had 'health action plans' and were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, podiatrists and specialists. One health professional told us, "Staff are always welcoming and helpful and if I need anything staff always seem to get it. No concerns from what I have seen."

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said, "Staff are very nice and very polite. They treat me with respect and dignity; staff are very good." A family member told us, "[Person's name] seems to be well looked after." Another family member said, "Staff who have been at the home a while are very good." A health professional told us, "Staff are very friendly and support residents as best they can." They also said, "I've seen good interactions with staff and residents."

Staff respected people's privacy and dignity. A family member told us, "Staff really treat my son with dignity; they do that well." We observed care was offered discreetly in order to maintain personal dignity. People's privacy was protected by ensuring all aspects of personal care were provided in their own rooms or in bathrooms around the home. Staff knocked on doors and waited for a response before entering people's rooms. One staff member told us, "Dignity is in people care plans. I always knock on people doors and make sure people are appropriately dressed. If someone had an accident I would privately guide them back into their room." Another staff member said, "I maintain dignity by closing doors and locking the door if they are in the bathroom and make sure I always knock first."

The provider had also taken action to ensure people's dignity. For example, special film had been placed on some bedroom windows so that people outside could not see into the rooms. In bathrooms, semi-opaque glass was used.

Staff had built up positive relationships with people. Staff spoke about their work with passion and spoke about people warmly. They also demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were, showing how they had taken the time to get to know people in their care. Staff showed respect for people by addressing them using their chosen name, maintaining eye contact and ensuring they spoke to people at their level. A health professional told us, "Staff seem knowledgeable about the residents." A staff member said, "Residents are great and treated really well." Another staff member told us, "Teamwork is really good here and the residents are lovely."

The home entered the Hampshire Care Awards 2015 and were the runner up in the 'care home of the year' category due to raising money for a national charity by holding coffee mornings and cake sales. Residents were all involved and held an art exhibition of their work and sold pictures for the charity and shared a summer tea party with the local community.

People were supported to be as independent as possible. Care plans contained information on people's progress towards personal goals with dates by which they were to be achieved. For example, one person had achieved their goal of helping to cook breakfast and tidy their room.

Confidential information, such as care records, were kept securely and only accessed by staff authorised to view them. When staff discussed people's care and treatment they were discreet and ensured conversations could not be overheard.

Requires Improvement

Is the service responsive?

Our findings

Care plans were detailed and provided information about how people's care and support needs should be met. They contained information about people's medical and physical needs. However, some care plans contained inaccuracies and missing information. For example, one section of a person's care plan it stated they had no allergies, but other sections stated they had hay fever and were allergic to a particular medicine. The person's dietary needs were also inaccurately recorded. Their care plan stated they were on a red meat and dairy free diet but staff said they ate meat and dairy. Records of the food they had eaten included yogurts, sausages and other meat. There was information about lactose free diets in their care plan but this was not being followed. Staff told us that the person was not on any dietary restrictions and that the information was out of date.

People were not always receiving the care as detailed in their care plans. For example one person's support plan stated 'keep active' but daily records showed they were not getting out for exercise daily. For example, in the week prior to the inspection, they had been out for a walk on the beach and a walk to local shops, but had otherwise stayed in the home or gone out for a drive. Staff said this was because the person needed two male staff to support them in the community. If out for a drive, this could be a female driver and male staff with the person. Duty rosters showed there were days when there was only one male staff member on duty.

We were told there were lots of concerns regarding one person when they became agitated and distressed. They put themselves or others at risk as their care plan did not contain much specific information or recording of their risks. Staff said that on occasions there were no predictors, on other times they described some possible indicators. However there were not clear recordings of risks including information about what happened before the incident, what the incident was or what happened as a result of any action staff took. This would enable staff or external health professionals such as psychologists to review the risks and determine appropriate action which may be taken to reduce the likelihood of future incidents. The persons care plan stated to manage risks by keeping them active and to ensure they do not become bored. However the persons daily records did not show that their days were filled with activities and when we first met them they were sat doing nothing in their private lounge area.

The failure to ensure care plans were appropriate to reflect the current needs of people using the service was a breach of Regulation 9 Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Care plans were personalised and contained information about what was important for people. One person liked to wear the same style and colour of clothes and staff supported them to do this. For another person we saw that personal belongings were important to them, especially their hat and gloves. We observed them in the home with their hat and gloves. One staff member told us, "The care plans are very helpful if you need information."

A handover meeting between staff at the start of each shift helped ensure that important information was shared, acted upon where necessary, and recorded to ensure people's progress was monitored. We observed the handover meeting on the day of our visit; staff provided a detailed description of how each

person was feeling, what they had done, eaten and enjoyed (or not enjoyed).

People were supported to participate in a range of social and leisure activities in line with their personal interests. One person told us, "I'm making cakes with one of the staff tomorrow, I enjoy making cakes." A family member told us, "It's a good home; they take him out a couple of times a week." A health professional said, "There seems to be a lot of activities for people." One person attended day services five days per week. We saw some photographs on the noticeboard of recent days out that people had enjoyed. The home had also recently held a 50's and 60's weekend, with music of the era, cake decorating and a barbeque. One staff member told us, "I'm taking one person out in the forest today as they like to go for a walk."

The home sought feedback through the use of quality assurance survey questionnaires sent to relatives and professionals. These were sent out in May 2016 and the home was still waiting for feedback. The registered manager told us they would analyse the feedback to identify any improvements that could be made.

The home had a complaints procedure and no complaints had been received in the past year. Where people could not complain themselves, staff were encouraged to complain on their behalf if they witnessed any bad practice.

Requires Improvement

Is the service well-led?

Our findings

The provider had introduced a series of audits and improved the way they monitored the quality and safety of the service. However, these had failed to ensure compliance with the regulations. For example, a recent audit of the environment did not identify that window restrictors were not suitable, and placed people in danger of falling out the window. Care plans were reviewed each month by the registered manager, to ensure they were up to date and met people's individual needs. However, the reviews had not identified that there were inaccuracies and missing information. Medication and infection control audits were also not effective and had not picked up that medicines could not be properly accounted for, that a person had been using an unfit mattress or that infection control risk assessments had not been completed. Therefore the systems you put in place to assess and monitor and mitigate the risks relating to the health, safety and welfare of people were not effective. The registered manager informed us that the provider carried out their last audit in June 2015 and the next one was due at the beginning of August 2016. The registered manager carried out monthly quality visits of the home and garden, staffing and people using the service. One of the observations from a recent quality check was that the home was in need of some deep cleaning.

The night before our inspection, the new manager and another senior staff member had undertaken an unannounced night time quality monitoring visit to the home. This had identified some concerns and immediate and appropriate action was taken. They told us they had undertaken the monitoring visit not because they had any concerns but because "there hadn't been one for a long time".

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service effectively were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home had a new manager at the service who was going to apply to be registered with CQC. The current registered manager was going to then become the area manager for the provider. Staff were feeling very positive about the new manager. Staff said they felt supported and valued by the new manager. One staff member said, "The new manager seems really nice and will get involved with people living here." Another staff member told us, "The new manager has come in with lots of ideas."

Although we identified concerns, when we spoke with people they said they liked living at the home and felt it was well-led. One person said, "Manager very nice and new manager seems very polite." A family member told us, "My only concern has been communication and I am not always kept informed as I should be. The new manger has already phoned me and kept me updated so it looks like that is improving." A staff member said, "If I have a problem I can always go and talk to someone."

Staff meetings were carried out regularly. The home had introduced a 'Carer of the month' scheme. Staff voted each month for a staff member they believed had gone above and beyond and the reasons why they should receive the award. Staff were them presented with a gift voucher as a reward for their hard work and dedication. The deputy manager told us, "We have lots of changes at the moment and trying to fit round staff. Trying to find the right balance with staff." A staff member told us, the goal of the home was to "keep

these guys [people] happy".

The provider and registered manager understood their responsibilities and the need to notify the Care Quality Commission) CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the appropriate care and treatment met peoples needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that the quality of the service was effectively monitored and improvements were not made as a result.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people were not at risk of receiving unsafe care relating to the health and safety of people using the service. People were not protected from harm by the safe management of medicines.

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant with the regulations by 12 September 2016.