

Miss Elizabeth White

Amber House

Inspection report

68-70 Avondale Road
Gorleston
Great Yarmouth
Norfolk
NR31 6DJ

Tel: 01493603513

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 24 and 26 July 2018 and was unannounced.

The last inspection was in June 2016, and the service was rated 'Good' in all key questions. At this inspection in July 2018, we found three breaches of regulation. This was related to person centred care, assessment of risk and governance.

Amber House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 22 people in one adapted building. At the time of this inspection there were 16 people living in the service.

There was a registered manager in post. 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.

The provider's governance systems had failed to identify the areas we found as requiring improvement. Auditing systems needed to be improved upon to ensure all areas of people's care was considered.

Risk assessments relating to people's care were not always sufficiently detailed, or reviewed regularly to ensure they were still relevant. Some did not contain sufficient detail to guide staff in how to mitigate risks.

Risks relating to the environment had not been identified by the provider, however, they acted promptly to address these.

Care plans were not standardised across the service. Some contained historical information that was no longer relevant, and inaccurate information about people's needs. Care plans were not reviewed regularly to ensure they contained up to date information about people's current needs.

Care plans in relation to people's end of life care needed to be more detailed to ensure the full scope of people's wishes were known.

People received their medicines safely, however, some improvements were needed in how the service stored temperature sensitive medicines and in documentation.

There was sufficient numbers of staff to support people safely, and to enable people to access the community and pursue their hobbies and interests.

Staff took appropriate precautions to ensure people were protected from the risk of acquired infections.

Staff had regular supervision and they had been trained to meet people's individual needs effectively.

The requirements of the Mental Capacity Act 2005 were being met, and staff understood their roles and responsibilities to seek people's consent prior to care and support being provided. People were supported to have maximum choice and control of their lives.

People had been supported to have enough to eat and drink to maintain their health and wellbeing. They were also supported to access healthcare services when required.

People were supported by caring, friendly and respectful staff.

The provider had an effective system to handle complaints and concerns.

The manager provided stable leadership and effective support to the staff. They worked well with staff to promote a caring and inclusive culture within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Risks relating to people's care were not regularly updated, and in some cases were inaccurate.

There were some environmental risks which could place people at risk of harm.

Recruitment procedures needed to be more robust.

People received their medicines safely, however, medicine storage facilities and some documentation needed improvement.

The provider had procedures in place designed to protect people from abuse.

Is the service effective?

Good ●

The service was effective.

People were supported by staff who were trained and knowledgeable about people living at the service.

Capacity and consent were considered, and where people were deprived of their liberty the correct authorisation had been applied for.

There was effective liaison with health care professionals.

Is the service caring?

Good ●

The service was caring.

Staff treated people in a caring and compassionate manner. Staff agreed that this was important and spoke kindly about the people they supported.

People's privacy and dignity was respected.

Visitors were welcomed into the service, and could visit at any

time.

Is the service responsive?

The service was not consistently responsive.

Care plans did not reflect people's current needs and how they would like their care to be delivered. Some information was inaccurate.

Opportunities were provided to help people pursue social interests and take part in meaningful activities relevant to their needs.

The service had systems in place for receiving, handling and responding appropriately to complaints.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Auditing systems had failed to identify areas requiring improvement.

The registered manager and provider were visible in the service and led by example.

The registered manager had a good working knowledge of the day to day running of the service. There was a positive culture within the staff team.

Requires Improvement ●

Amber House

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 checked 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 24 and 26 July 2018 and was unannounced. The inspection team consisted of two inspectors, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority quality assurance team prior to the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the time of inspection there were 16 people living at the service. To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with four people who lived at the service, one relative, the registered manager and provider, and two members of care and catering staff. Following the inspection we spoke with one health professional.

Is the service safe?

Our findings

At our previous inspection in June 2016, we rated this key question as Good. At this inspection in July 2018, we have changed the rating to 'requires improvement'. This was because risks were not always fully or regularly assessed to ensure they were mitigated as far as possible. This included risks relating to people's care, and those in the environment.

People's records contained risk assessments in relation to their risk of developing pressure ulcers, malnutrition, and other risks such as certain behaviours that might affect others. However, where screening tools had been used to assess the initial risk, these had not been regularly updated at the frequency specified in best practice guidance. The registered manager told us that risks were generally being updated annually. Some had not been reviewed since 2016/17. Additionally where people had been weighed, a full body mass index had not been completed to provide a calculated level of risk. One person had not been weighed recently as they were now unable to get out of bed. The service was not aware that there were other methods to estimate changes in weight over a period of time.

One person was being re-positioned two hourly to ensure their skin was intact. However, where the chart asked about the integrity of the skin, staff had not completed these properly; staff had recorded comments such as, 'had breakfast'. We brought this to the attention of the registered manager to ensure staff were documenting skin checks accurately. They confirmed the person had no pressure ulcers and despite the poorly completed documentation, was confident they were being repositioned regularly.

Some people were at risk of choking, and we saw some information was present to advise on how to feed people to avoid choking. However, this did not include actions staff should take if a person was to choke. One person was at extreme risk of choking, but there was not sufficient guidance in place to provide staff with action to take in the event that the person choked. Information relating to historical risks were also on one person's file. This detailed some personal information, which we later found out was no longer relevant to the care they received from staff. The risk had reduced significantly, but this had not been updated.

People's care records were not standardised across the service and it was very time consuming to determine what specific risks related to each person.

Risks relating to people's care constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day two of our inspection, the registered manager had identified people who were most at risk, and used best practice screening tools such as Waterlow (estimates the likelihood of developing a pressure ulcer) and MUST (malnutrition universal screening tool) to determine people's level of risk. Choking risk assessments were also in the process of being implemented, and contained relevant information, such as actions to reduce this risk.

The service had acted promptly to our concerns and showed us what was in place to mitigate the risks. Staff also informed us that up to date information relating to risks that affected people were held in a separate folder which staff were required to read and sign at start of each shift. A staff member told us, "[Registered manager] puts reviews and any new info in the daily folder. We all have to check every shift, read and sign to say we have read it. [Registered manager] will ask us random questions to check we have read it too."

During this inspection, we found environmental risks that could pose a risk to people's safety or welfare. For example, there was no fire evacuation equipment in the service, such as an evacuation sledge. In the event of an emergency this type of equipment can be used to aid the safe and prompt transfer of people out of the building. Records did not contain Personal Emergency Evacuation Plans (PEEPs). These show the support people require to evacuate the building in an emergency situation. We contacted the fire service who agreed to visit and offer the service advice. Following the inspection, the registered manager confirmed that evacuation equipment was now on the premises, and each person had a PEEP'S in place.

We observed that many of the radiators in the service were without covers, which could pose a risk of people scalding themselves were they to lean or fall against them. There were also exposed hot pipes in several areas of the service. After we shared our concerns with the registered manager, they sourced a company to fit radiator covers and to box in exposed pipes. This was later confirmed by the registered manager as having been completed.

There was a legionella risk assessment in place, however, it did not stipulate who to escalate concerns to and what action to take should issues be identified. One of the ways to reduce the risk of legionella is the effective control of water temperature. At the time of our visit we saw that hot water temperatures were being checked. However, this was the temperature before it reached the taps. Taps were fitted with thermostatic mixing valves (TMV) which moderate the temperature, but these temperatures were not being checked and we found that the water in some taps in the service were too hot. Following the inspection the registered manager confirmed that all taps were being checked in the service to ensure the temperatures did not pose a scalding risk. TMV's were added where needed and water temperatures reviewed in some areas of the service, such as baths, to ensure they were within safe limits.

There were several steep staircases around the service which did not have a gate to protect people from the risk of falling. Not all staircases had been risk assessed to identify if these were needed. Following the inspection the registered manager told us that they had assessed each staircase, and were had fitted stair gates to four of them having considered who uses them and the associated risks.

There was one hoist in the service which wasn't being used. However, it had not been serviced recently. The registered manager made arrangements for this following the inspection in case it was needed.

A pharmacist had recently visited and carried out an audit of the services' systems for managing medicines. Feedback was generally good, but some actions had been noted, and the service was in the process of addressing these, most of which had been met.

Staff handling and giving people their medicines had received training and observed competency checks. This is an observation of how staff safely handle and administer medicines. However, these were not always documented. The registered manager told us they would ensure they did so.

Medicine administration records (MAR) were generally well completed, however, we did find some gaps in records where staff had not signed to say medicines had been given. There were also no body maps in place for topical applications, such as creams, so staff knew which areas of the body to apply these. On day two of

the inspection, the registered manager told us these were put in place.

For people receiving medicines 'as required' there were no protocols to describe when these should be offered or what symptoms a person might present with; the registered manager told us they would implement these.

The temperature of the medicines storage room was monitored, and these were within the recommended safe limits. However, controlled drug temperatures were not being checked. Following the inspection, the registered manager informed us that this had been put in place immediately.

Medicines which were temperature sensitive were being stored in the main fridge in the kitchen where food was stored, and temperatures were being monitored. However, these medicines were not kept in a locked box, and we saw that people living in the service used the fridge. The service should have ensured medicines were kept in a separate, lockable box that has restricted and authorised access. If medicines that need to be kept in a fridge are used regularly then it would be appropriate for the service to consider having a designated medicines fridge in place. The service confirmed following the inspection that a fridge had been purchased.

We asked people if there were sufficient staff working in the service. One person told us, "Yes, there are several of them. If you press your buzzer they [staff] come quick." Another said, "Never have to wait, they [staff] spoil us." We observed throughout the inspection that there were staff available at all times; this included taking people out into the community. The registered manager told us that they flexed the staffing levels accordingly, for example, in the event of day trips out.

We saw that safeguarding information was available for people living in the service, visitors and staff. Staff had received training in safeguarding adults and knew how to report any concerns. One staff member said, "We have had a recent incident where we had to keep a person safe. I would report [concerns] to [registered manager] and there is also a number to call on the noticeboard for the safeguarding team. We asked people if they felt safe living in the service. One person said, "Yes I'm safe, I'm happy here." Another said, "Very safe." Staff showed an appropriate understanding of Safeguarding and an awareness of how to raise incidents both internally and to the Local Authority.

The Provider had appropriate recruitment processes in place. This involved the completion of a suitable application form, interview, references, and health and criminal record checks. However, it was noted that the provider sometimes received and in one case sought references after their start date. Fortunately, in each case the references were positive and there were no concerns about the suitability of staff. The provider must ensure that recruitment procedures are robust and that newly appointed staff have the necessary attributes and skills before they commence employment.

We observed that areas of the service were clean and fresh on the day of the inspection. However, we found some items in bathrooms which should not have been, such as shampoos, bath mats and protective equipment for staff such as gloves and aprons. When we pointed this out a staff member immediately called the infection control team for advice, and removed the items. This demonstrated a responsive approach to our feedback. There were adequate supplies of personal protective equipment, such as aprons and gloves, and we observed staff used these appropriately.

The service had ensured that lessons were learned and improvements made when things had gone wrong. Following this inspection, the registered manager and provider acted promptly to address our concerns and kept in contact to update us.

Is the service effective?

Our findings

At our previous inspection in June 2016 we rated this key question as Good. At this inspection we found that standards had been maintained, and the rating of Good continues for this key question.

The service considered the needs of people before they moved into the service. For example, one person was referred to the service for possible admission. We saw information the registered manager had sent to the local authority stating that they had fully considered the person's needs, and that they felt they would be unable to meet them. This was a responsible approach by the service. The registered manager told us that they carefully considered if people could be cared for safely, taking into account others who lived in the service.

However, there was an inconsistent approach to this at times. For example, one person had documentation on file from their previous care provider, but nothing completed by them. The registered manager told us their usual practice would be to meet with new people and gather information for themselves to determine if the placement would be suitable.

People told us they felt the staff were well trained. One person said, "The staff are very good." A relative told us, "Yes, I think they [staff] know what they're doing."

Staff were encouraged to assess their training needs and attend training. One member of Staff told us, "Any training we want, [registered manager] supports us to get it. This week we are doing the communication booklet that [registered manager] gave us. We have DOLS too. The certificate is on the door as you come in [from training provider]."

A training matrix showed that staff had received training in medicines, fire safety, moving and handling, safeguarding, and infection control. More specialised training was also arranged where needed, and we saw this had recently been the case where one person required staff to have additional knowledge in a particular area of their care.

Staff received supervision sessions which supported their learning and identified any areas requiring improvement. Supervision was carried out to a high standard and ensured staff developed their skills and knowledge. We saw regular and well-documented supervision, self-review, and observation in practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes

and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Appropriate DoLS applications had been made where people were being deprived of their liberty. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records generally showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests. Often other professionals had been involved in this process which was good practice. One professional told us, "Generally I find [Amber House] very good. They are well thought of by [professionals]."

Staff understood why some people had received mental capacity assessments and why best interest decisions were in place. Staff also understood why DoLS had been put in place.

We found one best interests decision in relation to how one person took their medicine's, and were told this was covertly administered. However, this was not being given covertly, but placed on food, with the person's knowledge. The best interests decision had not been reviewed since 2015, to ensure it was still relevant and up to date. The registered manager told us they would review this.

We saw that there was closed circuit television (CCTV) in several areas, which could impact on people's privacy. However, there were no mental capacity assessments or best interests decisions in place in relation to the use of the CCTV. Some people living in the home would not have been able to understand or consent to the use of CCTV. We discussed this with the registered manager, who said letters went out to family members at the time of installation, and that people were aware that it was in place. They said they would review the use of CCTV and carry out best interests meetings with family members for people who were unable to consent.

People had access to a range of healthcare services to meet their needs and to keep them well. This included speech and language therapy, GP's, learning disability nurses, and mental health professionals. The service worked with other professionals when required, and we saw evidence of communication when they needed advice, or to update them about people's care. People had care 'passports' [information about people's care needs] and, 'This is me' documents, which could be transferred between care services if needed. This provides other professionals with information about people and how they like to have their care delivered. We did however find that some information contained within these required updating.

People's nutritional, dietary and hydration needs were met as they received sufficient food and drink to nourish them and maintain their health and well-being. People told us their views on the food. One person said, "The meals are lovely. We get a choice and can ask for something else if we want. We have a roast on Sundays." Another told us, "The food's very good. I just had a sandwich and there's sausages later." And a third person, "Oh the food's lovely. I like bananas and custard, and rhubarb crumble and custard." We observed the lunchtime meal, which was a sociable and relaxed occasion. Staff were available at all times.

Where people required a specific meal type, such as pureed food, this was provided. People's individual dietary needs were catered for, and we saw there was liaison with relevant professionals where weight loss was a concern.

In the main, the home was well maintained, well decorated and welcoming. There were communal and private rooms available for people to relax, socialise and entertain their loved ones. People navigated around the service independently, some chose the garden, others chose to go to their rooms, whilst others watched TV in various places around the service.

Each person had their own furnished bedroom which we saw were decorated with their personal items such as photographs, ornaments and cuddly toys. Some areas of the service were a little in need of decoration, and some carpets were old. However, the provider had already identified this as an area for improvement and told us that as part of the ongoing flooring refurbishment, these would be replaced.

Is the service caring?

Our findings

At our previous inspection in June 2016 we rated this key question as Good. At this inspection we found that standards had been maintained, and the rating of Good continues for this key question.

People told us staff treated them with kindness and respect. One person told us, "They're [staff] very nice. They look after us and spoil us". Another said, "It's [relationship with care staff] very good." A relative said, "Lovely staff they really care."

People were supported by staff who understood their needs and preferences. Care records did not always contain person centred information. However, we observed that staff knew people very well, they knew their preferences and how they liked to be supported with their care. Staff could tell us about people's needs and preferences very accurately. Many staff appeared to instinctively know what people wanted.

People told us they felt safe and were well cared for in the home. The quality of interactions between staff and people was observed throughout the day. Staff and the registered provider spent time talking with people in the garden throughout the time we were there. People asked staff for help whenever they needed it, and were seen to be confident in doing so.

When we arrived at Amber House, it was a very warm day. We observed that a paddling pool had been prepared for people to use in the garden. We observed people laughing and splashing around with the water. When people were ready to lift their feet out of the paddling pool a staff member knelt down and dried each person's feet and made sure their shoes were available. When one person became unsettled after lunch we saw a member of staff took them out for a walk on the seafront, which included an ice cream. We observed how much more settled this person was when they came back to the home.

The provider was observed playing 'swing-ball' in the garden with people. They were relaxed with people, sitting under the shade of the garden umbrellas, chatting about past events and encouraging discussion and ideas for future activities. There was a respect for the people who lived in the home and the feeling of a relaxed caring environment.

People had their own self-contained rooms which afforded them the privacy they needed. They told us they could choose to stay in their rooms anytime and nobody would bother them. We observed this during the day. We saw that staff carried out any intimate tasks in private behind closed doors to ensure people's dignity was maintained always. We noted that staff always knocked on people's bedroom doors and awaited a response before entering. When the registered manager took us on a tour of the building they always knocked on each person's door before entering, even though in most cases people were in other parts of the service.

'Residents' meetings were held monthly in the service so people had the opportunity to give their views. We saw that relevant items were discussed, including food and activities. Visitors were permitted to visit the service at any time, and we saw relatives coming in and out during the day.

Is the service responsive?

Our findings

At our previous inspection in June 2016 we rated this key question as Good. At this inspection we found care plans needed to be more detailed, current, and personalised. We have therefore rated this key question as 'requires improvement'.

People's records included care plans. These care plans explained people's needs in areas such as dietary needs, personal hygiene, communication and continence. The level of detail held in each care plan was not consistent. The care plans were not standardised to help staff to find relevant guidance. Some areas were no longer relevant, and some contained inaccurate information. Care plans had not been reviewed regularly to ensure the content was relevant and up to date. Some had not been reviewed in over 12 months. We also found that some historical personal data was being held on people's care plans which was no longer relevant. This made it very difficult and time consuming to navigate through the care plan and understand people's current needs.

Care plans made little reference to people's end of life wishes, such as where they wanted to be cared for, and who to contact. They did not reflect the full scope of people's wishes, such as how they wished to spend their last days. Some just asked if the person wanted a burial or cremation.

This above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager told us that there were no people nearing the end of their life. However, they were already looking to improve this aspect of people's care plans. They told us they would liaise with relevant professionals if a person was nearing the end of their life to ensure care was in line with best practice. We also saw that six staff had recently completed training in end of life care.

In relation to the people whose care we reviewed, we checked the practical arrangements in place and were satisfied that they were receiving the appropriate support. When we spoke to staff they knew people well, and any risks associated with their care.

The registered manager told us they would start reviewing people's care plans to ensure only relevant information was held and that people's health and care needs were accurate.

People were encouraged to take part in activities of their choosing. When we arrived, we found a paddling pool was placed in the garden and people were encouraged to dip their feet in as it was a very warm day. We saw four people playing dominoes in the shade and staff were encouraging them where needed. There were colouring books, pens and crayons and people were drawing. In the afternoon, staff and people played bowls and swing-ball. We overheard a member of staff ask a person, "what would you like to do this afternoon", and a full discussion took place. This demonstrated that people had a choice about how they spent their time.

We observed materials and paintings in the activities room together with the many photographs of past events and outings undertaken by the service. The registered manager told us the service had to increase the amount of activity they provided, when several people could no longer attend a day centre which had closed. An activities room had been set up and staff were trained to do more with people. One staff member told us, "It was my idea to create the [activity room] and it was created within a week. We had a party to celebrate it opening."

An outing to a local recreational area had been planned prior to the day of our inspection, but with the hot weather and the registered manager recognising we wanted to spend time with people and staff during the day, it was decided to postpone the trip. People had access to the community, and we saw people coming and going throughout the day. Some people went out with family members, and some with staff. One person said, "I like to do colouring and sit on the garden swing. We play games like dominoes and I was paddling before."

The service had not received any complaints, but had a complaints procedure in place. People and relatives had the opportunity to share their views in residents meetings, and also via a survey that was issued annually. There was a template for people to give their views in an easy to read format supported by pictorial signs and symbols.

Is the service well-led?

Our findings

At our previous inspection in June 2016 we rated this key question as Good. At this inspection we found that auditing processes needed to be more robust in order to identify areas for improvement. We have therefore changed the rating in well-led to 'requires improvement'.

The registered manager was supported by the provider, who registered with the Care Quality Commission in September 2017. The registered manager and provider were very responsive to our feedback during the inspection. They understood the need for improvement, and took prompt action to address the issues.

However, the providers auditing systems had not been effective in identifying the areas we found as requiring improvement. This included care plans, assessment of risk, medicines, recruitment processes, and environmental risks.

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

Quality monitoring systems in place included health and safety, medicines, hand hygiene, infection control and mattress checks. However, auditing systems should be continually reviewed to make sure they remain fit for purpose and highlight areas where the service is performing well and the areas which require development. This also helps to ensure there is a focus on continual improvement.

There was a clear vision to deliver high quality care and support at the service. The registered manager had developed and embedded positive relationships with staff and there was an open, inclusive, and person centred culture throughout the service. There was a clear desire to provide people with choice as to how they lived their lives and to provide them with a safe, supported and caring environment.

The registered manager provided meaningful and regular in-depth supervisions with staff which facilitated open discussion about staff development and progression. There were also monthly staff meetings, which are a valuable means of motivating staff and keeping them informed of any developments within the service.

Staff were compassionate and caring in their approach and felt supported by the management team. People told us they knew who the registered manager was and felt they had a good relationship with her. We also observed this to be the case. We saw one person go over to the registered manager, hugged them, and said, "She's the best". We also observed that the provider was visible in the service, and spent time with people in a caring way. They were actively involved in the service, and told us they liked being in the service to help the registered manager.

Staff were clear about what was expected of them in their roles and were motivated to provide effective care. The staff we met with all spoke highly of the registered manager, the provider and the staff team as a whole. Staff were enthusiastic in their work and comfortable in their roles. We also saw that the entire staff

team worked cohesively together. One staff member said, "I can speak openly. I feel I can go to [registered manager] or [provider]. I wouldn't want to work anywhere else." Another said, "I do love my job. I came in today because I wanted to."

Surveys were issued to people, relatives, professionals and staff as a way of gaining feedback about the service. We saw these were mainly positive, and the registered manager had created action plans where needed as a result of feedback.

The service worked with other professionals to ensure people received a good standard of care. This included learning disability nurses, mental health teams and therapy services.

It is a legal requirement for all services that have been inspected by the CQC and been awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. We found that the rating from the last CQC inspection was displayed prominently in the entrance hall.

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 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People's care plans did not always reflect their current needs. Staff did not have accurate and up to date information on people's needs to refer to.</p> <p>9 (1) (3) (a)</p>
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>Risks were not reviewed regularly and in some cases did not contain sufficient detail to enable staff to have sufficient guidance in how to mitigate risks.</p> <p>Risks relating to the environment had not been identified by the provider.</p> <p>12 (1) (2) (a)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Auditing systems had failed to identify where quality and safety were being compromised.</p> <p>Regulation 17 (1) (2) (a)</p>

