Barchester Healthcare Homes Limited

Lindum House

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected this service on the 5 July 2017. The inspection was unannounced. At the last inspection in May 2016, we asked the provider to take action to make improvements to the safety of medicines management, the support of staff to enable them to carry out their duties, meeting people's needs and quality assurance systems. At this inspection we found that these actions had been completed.

Lindum House is registered to provide nursing care for up to 64 older people, some of whom were living with dementia. At the time of our visit 46 people were living at the service.

A registered manager was employed at the service. 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.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about different types of abuse and were aware of action they should take if abuse was suspected. We saw all incidents of suspected abuse had been reported to the local authority and CQC had received notifications of these events.

There were systems in place to monitor and improve the quality of the service provided. We saw there were a range of audits carried out both by the manager and provider. We saw where issues had been identified action plans with agreed timescales were in place to help drive improvements. However the provider audits had not highlighted that the environment was not adapted for people living with dementia.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what we asked the provider to do at the back of the full report.

Improvements had been made to medicines management and people received their medicines safely.

Risk assessments were in people's care plans for areas such as moving and handling, falls and pressure care so staff knew how to support people to remain safe. However, these did not reflect the capacity of the person or the care given in every case.

We saw people's care plans contained person centred detail. Staff knew people very well. As part of the 'resident of the day initiative' the manager told us they reviewed people's care plans and risk assessments. Where people did not have capacity staff had carried out an assessment and made decisions in the person's best interest. However, we saw this had not happened for one person.

We made a recommendation that the provider should use good practice guidance around MCA and best interest decision making to ensure staff can support people to make decisions in accordance with MCA

guidance.

Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety.

Following the last inspection the manager had implemented robust systems to ensure staff felt supported through supervision, appraisal, training and staff meetings. Staff told us they felt positive about the changes and felt very well supported by the manager.

The manager had analysed staffing levels that were needed. The rotas reflected these numbers but at times staff were very busy. The service would benefit from staff being deployed more efficiently. We concluded that people had enough staff to meet their needs.

We found safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

There were positive interactions between people and staff. We saw staff treated people with dignity and respect. Staff were attentive and patient with people. Observation of the staff showed they knew the people very well and could anticipate their needs. People and their relatives told us they were happy and felt very well cared for.

People told us they enjoyed their food and a choice was offered at mealtimes. We saw the mealtime experience was positive. People had their weight monitored to ensure they were receiving enough nutrition and where there were concerns, appropriate referrals had been made to professionals.

People's independence was encouraged and we saw there was a variety of activities organised for people.

People and relatives were asked for their views through surveys and day to day conversations. They said they would talk to the manager or staff if they were unhappy or had any concerns. They told us they felt confident to do this.

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

This service was safe.

People's medicines were managed safely in line with the service policy and procedure and national guidelines.

Risks had been identified in relation to people's health and safety and were recorded. The premises and equipment were maintained and serviced within recommended timescales.

People were safeguarded against abuse because staff were trained and incidents monitored,. Staff recruitment was robust.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The environment did not support the needs of everyone because it had not been adapted to make it dementia friendly. There were a high number of people living with dementia at the service.

Although staff had been trained in MCA and best interest decision making the training did not translate into practice for every person.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People felt that staff cared and we observed many positive interactions between people and staff. Relatives echoed this view.

Staff worked in a way that protected people's privacy and dignity.

People were encouraged to retain their independence as far as possible by staff.

Is the service responsive?

Good

The service was responsive.

There were activities on offer for people which were well planned and varied.

Care was focused on each person but improvements could be made to ensure changes were recorded in care plans when they occurred.

Complaints had been managed in line with the service policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was an experienced manager employed. People, their relatives and staff described them as approachable.

Audits and checks had been completed at the service and had identified the issues we found during the inspection except the need for more dementia friendly adaptations to the environment.

Feedback had been sought using surveys conducted by an independent organisation.

Lindum 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 was planned to check whether the registered 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 5 July 2017. The inspection team consisted of one adult social care (ASC) inspector, a specialist advisor who was a registered general nurse and had experience of dementia and two Experts-by-Experience who both had knowledge and experience of older people and dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. Statutory notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. This information assisted us in planning the inspection.

At this inspection we spoke with the manager, the deputy manager, a registered nurse, a senior care worker, three care workers, the chef and the activities person. We spoke in private with eight relatives and thirteen people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the lunchtime in two dining rooms, activities and the interactions between people, visitors and staff in the communal areas. We observed the administration of medicines at two different times and checked that medicines were managed safely. We looked around the service including communal areas, the gardens and people's bedrooms with their permission.

We spent time reviewing the care records for five people in detail and a further six people to check specific information. We also inspected the recruitment, induction, training and supervision records for six members

of staff and other records relating to the management of the service such as maintenance and servicing documents and audits of different areas of the service.

Good

Is the service safe?

Our findings

We had identified concerns relating to the safe management of medicines at our previous inspection in May 2016. During this inspection, we checked to see what improvements had been made. We looked at 15 Medicines Administration Records (MARs) and spoke with a registered nurse and a senior carer responsible for administering medicines. We found that improvements had been made to the medicine management systems.

People told us, "Staff are very keen to make sure I get my tablets regularly." A relative with lasting power of attorney told us they had been involved in discussions about their relative's medicines with staff. Immediately prior to lunch a member of staff gave one person their medicine and after addressing them by name said , 'I've got your [Name of condition] tablets for you." These were tablets that had to be given at specific times and we saw they had been given according to instructions.

Medicines were stored securely in locked rooms and access was restricted to authorised staff who held the key. There were appropriate arrangements in place for the management of controlled drugs. These are medicines which require stricter legal controls to be applied to prevent them: being misused, being obtained illegally or causing harm. They were stored in a controlled drugs cupboard and staff regularly carried out stock balance checks in accordance with the home's policy.

Room and fridge temperatures where medicines were store were recorded daily, and these were within recommended limits.

Medicines prescribed to be given only as and when people required them, known as 'when required' or 'PRN' had protocols completed so that staff knew when and why to give them. In addition, there were MARs in place for topical medicines which showed where the cream was to be applied. This meant that staff had enough information to administer the treatment intended by the prescriber. However, where 'when required' pain relieving medicines were prescribed staff would benefit from having supporting information to help them identify symptoms for people who could not express themselves when they were in pain.

One person was being given medicines in food or drink following decision making by healthcare professionals and family who decided it was in the person's best interests. We checked care records and found that the decision had been made in accordance with the Mental Capacity Act 2005.

Medicine audits had been completed and staff had received medicines handling training and had their competency to administer medicines assessed regularly to make sure they had the necessary skills.

We had identified concerns relating to risk assessments at the last inspection. During this inspection we saw risks had been assessed relating to people's health and wellbeing and these were monitored. We saw that one person's risk assessment for falls had been reassessed during the last month. There were risk assessments in people's care records for aspects of their care that included areas such as moving and handling, falls, skin damage and choking. However, we saw that despite the risk of choking being identified

for one person, a care worker gave them a normal diet instead of pureed meat and fork mashable vegetables which had been advised by the speech and language therapy team (SALT) team. The person came to no harm as the food was removed immediately and we saw no other incidents to suggest that people across the service were at risk. We checked and found that the kitchen staff had prepared the correct diet for this person and were aware of their dietary needs. Other staff were also aware of what they should eat from assessments and care plans. We concluded that this was an isolated incident. We spoke to the registered manager who expressed surprise that this had happened. They said they would look into this, speak to the staff and learn from it.

The risks associated with people's health and safety within the environment had been assessed. Maintenance of equipment had been completed within the recommended timescales and servicing was carried out at appropriate intervals. This included fire safety equipment, lifting equipment, gas and electrical equipment.

People we spoke with who lived at Lindum House told us they felt safe living there. One resident said "It feels safe and homely here" and another said, "The staff come quickly when I press my buzzer." Other comments included, "I feel if I have need of help I get it whereas at home I would be on my own" and, "I feel safe." When we asked one person what they considered being safe meant they told us they felt safe because, "People can't get into building" and, " If I felt concerned I would push the buzzer (call bell)."

There were safeguarding policies and procedures in place to guide staff in safeguarding people from abuse. There had been seven safeguarding alerts in the last year all of which had been investigated. Staff had received training and could tell us how they would report any concerns about abuse to their manager. They were confident that allegations would be taken seriously and acted upon. This ensured that as far as possible people were kept safe from the risk of abuse.

Staff had been recruited safely. Application forms were completed, references obtained and checks made with the Disclosure and Barring Service (DBS). DBS checks provide criminal record checks and information about whether or not people are on any lists preventing them from working with adults or children. DBS checks help employers make safer decisions and prevent unsuitable people from working with people who may be vulnerable. The manager carried out regular checks with the Nursing and Midwifery Council to check nurses employed by the service had active registrations to practice.

People told us they thought there were enough staff to meet their needs. However, there was an acceptance amongst people we spoke with that they may have to wait a short time for assistance if they pressed their call bell with one person saying, "Normally I have to wait a bit and sometimes they are quick. It is to be expected: there are a lot of people." Comments from relatives confirmed this view. One relative said, "I would be happier if there were more staff as they are very tired by the end of their long shifts." Another relative told us "There are not enough carers in the lounge (upstairs)" and a third said, "They do the best they can." Over the course of the day we saw that people were sometimes left unattended for short periods in the upstairs lounge.

A dependency level tool was used by the manager to calculate the staffing levels required to meet the needs of people who used the service. This information was intended to help the manager provide care for people by supporting decisions on the overall staffing of the home. We were given a copy of the tool used to calculate staffing levels completed on 4 July 2017 for 45 people. This indicated that the service were short of 5 staff hours downstairs but upstairs staffing was 7.6 hours over what was needed which meant that overall the staffing was in excess of what the dependency tool had suggested was needed.

However, downstairs we saw that one person had called for assistance. A care worker had answered the call and the person told us they had said they would return in "Two minutes but that probably means ten (minutes)." The person told us they thought staff were very busy as it was lunch time and confirmed they were ,"Happy to wait." After five minutes they used the call bell again but no-one came and we asked a care worker to attend to the person. We also spoke to another person who had used their call bell. They said, I usually wait five minutes or so." The call was responded to after eight minutes.

We checked the rotas and saw that they reflected what the dependency tool had assessed as staff numbers required. There was a registered nurse, a senior care worker and seven care workers to care for 46 people. There was also additional kitchen staff, domestic staff, a maintenance person and an activities person. This suggested that staffing was sufficient but that staff were not always deployed effectively at busy times.

Requires Improvement

Is the service effective?

Our findings

Staff were supported through regular supervision. Supervision is a process, usually a one to one meeting with a senior member of staff to discuss work related matters, training and development. Supervisions were recorded and up to date. Registered nurses told us that they used the National Institute for Health and Care Excellence (NICE) guidelines to support them and keep them up to date with best practice. One care worker told us, "We now have supervision every two to three months and an annual appraisal."

People told us that they were content with the care provided by staff and one person told us, "As far as I know they are well trained." One relative told us, "They are very good at keeping us informed." Staff had the necessary skills and knowledge to meet people's needs in most cases.

When people started working at the service, they had an induction period during which they familiarised themselves with the service, as well as carrying out training for four days away from the service. Training was completed by all staff in subjects such as health and safety, infection control, mental capacity and deprivation of liberty safeguards (DoLS), safeguarding, moving and handling and fire safety. Nurses were trained to provide first aid as they covered every shift and had competency checks in administration of medicines. In addition the nurses had done additional specialist training where it was needed. For example they had been trained to assist a person with the cough assist machine by the respiratory nurse. The cough assist machine helps to clear secretions from the lungs by helping you with your breathing.

The service had benefited from the 'Wow' programme. This meant that some communal areas and six bedrooms on the ground and first floors had been completely refurbished There was an area on the ground floor where people could access coffee and tea making facilities and sit and chat. Corridors throughout the building were wide and mainly straight with no obstacles, making it easy for the people to move around if they wished. They gave good lines of sight for the staff to identify if people needed assistance. There were signs on rooms such as the toilets and bathrooms.

However, 21 out of 46 people who were using the service during the inspection had some form of cognitive impairment, confusion or were living with dementia. The building was not dementia friendly and had not benefited from the 10.60.6 programme run by Barchester. 10.60.6 is a training and accreditation programme designed to enhance the dementia care environment and improve interactions between staff, people living with dementia, relatives and health professionals. The environment had very little signage and colour contrast was not used as a means of supporting people to find their way around the building. We heard one person frequently asking where they should go. The corridors all looked very similar and the doors, apart from different numbers, were the same. There were small name plates on the doors but nothing else to help identify a person's room. The environment did not meet or support people's needs. The manager did inform us that this area was to be reviewed by a dementia care specialist employed by the provider.

This was a breach of Regulation 15 of the Health and Social Care Act 2008(Regulated Activities) Regulations.

When people had any healthcare needs advice and support had been sought from healthcare professionals.

All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken. One person told us, "I have had the doctor a few times" and a second person said, "I've only seen the doctor twice, I did ask for a doctor today." We saw that other healthcare professionals had visited people at the service such as the SALT team and a respiratory nurse. A district nurse visited someone during the inspection.

People's nutritional needs were met. Staff used the Malnutrition Universal Screening Tool (MUST). MUST is a tool used monitor whether or not people are at risk of malnutrition. In order to complete the tool people were weighed regularly. The tool was used alongside choking and swallowing risk assessments to provide a comprehensive overview of each person's nutrition needs.

People were assisted to the dining rooms on the ground and first floors and staff asked them where they would like to sit. Care workers did not serve lunch until everyone was seated. Tables were set with table cloths, cutlery and condiments. People were offered clothes protectors if they wanted to use them. If people required support to cut up food this was done discreetly by care workers. One person had difficulty getting food on to their fork. As soon as a care worker noticed they attached a plate guard to enable them to eat independently. One person told us, "They (staff) are very good at cutting up and preparing it (food) for me."

Comments from people about food included, "The food is very good"; "The food is not bad at all, depends what you like, what you are used to. There are always two choices and you can have a cooked meal at tea time if you want or can have something lighter like scrambled egg. I once asked if they had toasted tea cake. The first time they didn't have it but the next time they did" and, "The food is very good, it suits me, I'm not a big eater."

Where people chose to eat at times other then set mealtimes this was accommodated. One person had fallen asleep at the table and staff could not rouse them to eat their lunch. We checked later and saw they had been given sandwiches when they woke.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that six people who used the service had a DoLS in place, restricting their freedom of movement and applications had been sent for a further 25 people. Documentation was completed appropriately by the manager and deputy manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS. Emails had been sent from the local authority to confirm that they had received the applications and were processing them. All staff had completed training on Mental Capacity awareness and could describe how and why this legislation was used. However, there was a need for this training to be further embedded in practice as some staff we spoke with were unsure about how the DoLS and MCA legislation applied to people who used the service.

There was some variation in staff practices when assessing the mental capacity of people. We saw that for most people the correct steps had been followed when assessing their capacity and making decisions in their best interests. This included involvement of families and other professionals. However, appropriate steps had not always been taken to ensure people's capacity was assessed in order to record their ability to make complex decisions. There was a decision recorded in one person's file to say they had capacity to decide whether or not to have bed safety rails. On the assessment tool used by staff they were described as at high risk because of poor cognitive ability. Staff had been instructed to assist with orientating the person. There was no assessment of their mental capacity within their care file. When we spoke with staff they described the person as having fluctuating capacity. It was clear that bed safety rails were needed and had a positive impact in keeping the person safe but the correct process to reach that decision had not been followed. However, for other people we saw that the correct steps had been followed when assessing their capacity and making decisions in their best interests. This included involvement of families and other professionals. Staff asked people for their consent before carrying out care tasks and consulting them about their care.

We recommend that the service seek advice and guidance from a reputable source about use of the Mental Capacity Act 2005.

Good

Is the service caring?

Our findings

People and their relatives told us they were very happy and that staff were caring. One person said, "The majority of carers are very helpful, all very active, I can't say that anybody is not caring" and, "The girls are kind and attentive." Another person told us, "One member of staff comes in when she is off duty to have a chat with me, she is a tremendous lady."

Relatives told us, "The staff are so friendly, they know (relative) inside out," and, "The staff are very friendly, very willing. I don't worry about (resident) in respect of care." Observation of the staff showed they knew the people very well and could anticipate their needs. One care worker told us, "People just need to know they are loved."

There was a calm and relaxed atmosphere at the service and staff engaged with people in a very caring and friendly way. Staff were polite and sensitive to people's needs.

Very warm and meaningful interactions were seen where staff including ancillary staff (such as maintenance and housekeeping staff) took time to engage in conversations. We saw people responded by smiling and actively engaging in the conversations.

Staff worked in a way that protected people's privacy and dignity. For example, they told us about the importance of knocking on people's doors and asking permission to come in before opening the door. People told us staff were, "Very gentle and understanding" and "They don't leave you bare." One person said staff were, "Very keen on privacy; make sure if they are doing anything that the door is closed." A member of staff explained, "I knock before I enter and close the door if providing personal care." This showed that staff were committed to delivering a service that had compassion and respect for people.

We saw people could move freely around the service and could choose where to sit and spend their recreational time. The service was spacious and allowed people to spend time on their own if they wanted to in a choice of lounges, their bedrooms or other areas such as the coffee bar. We saw people were able to go to their rooms at any time during the day to spend time on their own. This allowed them time to themselves.

Some people told us they had been involved in planning their care but others could not remember seeing a care plan. One person said, "I don't think so but I may have forgotten" and another told us, "I saw my care plan when I first came." A third person said, "I know there is one; if I asked to see it they would help me." People and staff would benefit from a more consistent approach to involvement.

Staff we spoke with said where possible they encouraged people to be independent and make choices such as what they wanted to wear, carry out their own personal care where they could and allowing them to express themselves. We saw people were supported to mobilise independently and staff made sure people walked if they were able. One person told us, "The staff support me to do what I can for myself."

A resident's ambassador had been appointed who was a person who used the service. They spoke on behalf of the people living at Lindum House. At the time of the inspection people who required an advocate had access to one. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights.

Friends and relatives were able to visit at any time. Relatives told us that they felt welcome and had a good relationship with the staff. They said they felt involved in decisions about the health and welfare of their loved ones

Good

Is the service responsive?

Our findings

People and their relatives told us they were involved in a variety of activities. There was a list of the planned weekly activities displayed in the entrance for visitors to see and people told us they received a list of the activities each week. On the day of the inspection there was a planned visit by a pat dog and a 'Knit & Natter' session in the afternoon. Both of these activities took place and, in addition, a religious service took place in one of the lounges.

People enjoyed the visit by the dog and its owner who we were told were regular visitors to the service. One person happily showed us a photograph of herself with the dog sat on her knee. The activity co-ordinator accompanied them into the lounge and to visit people in their rooms making the visit inclusive for everyone.

The 'Knit & Natter' session was attended by six residents although only two were knitting. They were making a friendship blanket which was decorated with pom- poms. The activity organiser encouraged conversation talking about trips and events the previous week such as Wimbledon when people had worn hats and had strawberries and cream. During the afternoon two of the care workers were playing dominoes with three people in the café area.

One person told us, "I see a lot of visitors as I used to live locally. There are trips out but I haven't been on many as always have visitors coming. I've been to exercise to music and it was entertainment yesterday. They had a man playing an instrument and singing to it; quite a lot of activities for those who want to get out." Another person said, "I have my hair done every Wednesday or Thursday; nails as well every 2/3 weeks." A third person said," I take part in activities if I can, I don't go on outings because of my hips; my own choice not to go because I am not comfortable on the bus." A relative told us, "My (relative) has been out to the garden centre and to the cinema."

One person who was in bed told us the activity organiser, "Comes and brings a sheet with activities; she does shopping." Activities had sometimes been developed around people's own hobbies and interests. One person who was interested in plants said, "Sometimes the gardener takes me out in the garden and nobody minds if we have a nice long chat." A second person showed us photographs taken on their birthday and told us, "The staff made me a cake." However, people living with dementia would benefit from more activity to add meaning to their days such as been asked if they wish to participate in household tasks.

Care was person centred and although changes were recorded within the care file, care plans had not always been updated to show when people's needs had changed. For example, one person was living with dementia but their mental capacity had not been recorded although all the changes to their mental health were recorded within their records. We saw people's needs had been individually assessed and detailed care plans written. The care plans we looked at included detailed plans for staff to follow and where people had diabetes these plans had been written in some detail. Details of people's personal preferences, likes and dislikes were recorded.

The service had started to implement a 'resident of the day' initiative which meant that each month people

were reviewed in all areas of their care at the service. For example, their care would be reviewed along with their environment, meals, likes, dislikes, cleanliness of their room, maintenance of all their equipment and any other areas that were relevant to the person. The manager told us that this should ensure that each person had a full review every month and their records be kept fully updated.

We looked at the records of complaints that had been received and saw they had been dealt with in line with the service policy. People we spoke with had not made a complaint about their care, but they told us if they had a problem they would speak to the manager. All of the relatives we spoke with said they would not hesitate to raise concerns with the manager if they needed to.

Requires Improvement

Is the service well-led?

Our findings

We looked at the arrangements in place for monitoring the quality of the service. The manager was able to show us numerous checks which had been carried out on a monthly basis by the in-house team to ensure the service was run in the best interests of people. These included audits and checks of areas such as health and safety, medicines, infection control and housekeeping amongst other areas. This helped to ensure the service continued to identify areas for improvement. The areas we had identified throughout the inspection had been identified within these audits with the exception of the environment for people living with dementia.

We recommend that the service research best practice around quality assuring dementia care environments.

There was a registered manager employed at the service who had been in post for over two years but had worked for Barchester since 2010 at another service. Staff told us, "The manager is open and approachable" and "I can approach the manager at any time." People who used the service told us, "I would know her if I saw her"; "The manager comes by once or twice a day, waves as she passes, don't think she has the time to come and talk" and, "The manager is approachable, her door is always open. I've sat in her office and chatted and had a cup of tea; seems to make time for relatives."

Staff described the culture of the service as, "Good" and, "Transparent and honest." Staff were clearly in tune with this approach and behaved the same way throughout the inspection.

Residents meetings were held on a regular basis in order that people could share their views and ensure the service was run in their best interests. We saw a comment in the minutes of the meeting on 19 April 2017 saying, "Food has got progressively worse." The minutes of the meeting on 2 June 2017 recorded, "The food has improved after the last meeting. The chef came to see me." This demonstrated that people's views were listened to in order to improve areas of the service.

Staff were also supported through regular meetings and workshops. There were meetings for nurses and senior care workers and general managers which were held separately. Any information was cascaded to staff through their own meetings.

A survey had been completed to ask people and their families for feedback. This identified areas for improvement and positive attributes of the service. We asked people what they thought and one person whose relative had only recently moved to the service said, "We are really pleased; like the staff; no faults at the moment."

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 15 HSCA RA Regulations 2014 Premises and equipment The environment did not meet people's specific needs in all cases and had not been adapted to support their disability.