Future Care Services (UK) Limited

Royal Oak Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 February 2017 and was unannounced. The service was registered in October 2016. This was the first comprehensive inspection and was conducted in response to the receipt of concerns relating to safety and care practice.

Royal Oak Care Home is a purpose-built home offering personal and nursing care. Including residential, specialist residential dementia care, general nursing care and respite care. Care is provided over three floors. The service can provide en-suite accommodation and care for a maximum of 74 people. At the time of the inspection 17 people were living at Royal Oak Care Home.

A registered manager was 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.

Prior to the inspection we received information of concern which alleged that medicines were not being managed safely. We wrote to the provider requesting information about these concerns. We looked at the processes for the safe management of medicines within the service and spot-checked medicine administration record (MAR) sheets. We saw evidence that medicines were not always safely administered and recorded. We found a breach of regulation regarding this.

On an escorted tour of the service we were alerted to uneven floors on the first and second stories. There was significant bowing of the floors in a number of areas which created a risk for people, especially those with mobility difficulties.

Prior to the inspection we received information of concern alleging that a fire door did not function properly. We wrote to the provider requesting information about these concerns. As part of this inspection we assessed the functionality of fire doors throughout the service. We saw that two fire doors did not function correctly meaning that they would not be effective in reducing the spread of fire. We found a breach of regulation regarding this.

Prior to the inspection we had received information of concern which alleged that people were not adequately protected from the risk of harassment and poor care. We wrote to the provider requesting information about these concerns. Risk was not consistently and safely managed within the service. Risk assessments lacked detail and the files themselves were not presented in a consistent order which made it more difficult to locate important information.

Some people were not getting care as defined in their care plan. For example, for one person, we saw that

they were at risk of weight loss. The care plan stated that the person needed to be weighed weekly. When we checked we saw weight recordings were eleven days apart in one instance and despite this and the family expressing concern, they were not weighed again until two weeks later. We found a breach of regulation regarding this.

Staff told us that they were given informal supervision on a regular basis. However, records relating to formal supervisions indicated that meetings had been held with two members of staff since October 2016. Training was a mixture of e-learning and classroom based activity. Staff were trained in subjects relevant to their roles including; moving and handling, adult safeguarding and first aid. However, the records relating to training were unclear. We made a recommendation regarding this.

Capacity was only assessed on a generic basis with no consideration of people's capacity to consent to specific aspects of their care. Not all staff had been trained in the Mental Capacity Act 2005 (MCA) as required by the provider. The records that we saw did not clearly demonstrate that the service was operating in accordance with the MCA. We made a recommendation regarding this.

Although the service had been designed to meet the needs of people living with dementia there were no obvious signs of appropriate adaptations. For example, accessible signage to help people to use the building more independently, or objects of reference to assist them in identifying their own rooms. We made a recommendation regarding this.

People were supported with their healthcare needs by the nurses and through contact with community based healthcare services. District nurses were in regular attendance and referrals were made to other community based services as required. However, some healthcare referrals were not clearly evidenced within care records.

People's privacy and dignity were promoted by staff and people told us that they felt respected. However, we reported on two occasions that confidential information had been left on the same nurses' station where it could be easily accessed by other people living at Royal Court or visitors.

Records relating to assessment and care planning were not consistently completed or reviewed to an acceptable standard. This meant that people were placed at risk of receiving inappropriate or inadequate care. Other records associated with the care plans were confusing, lacking in detail and were not consistently completed. We found a breach of regulation regarding this.

Person-centred information was not consistently recorded in care files. The files that we looked at contained limited or no information relating to what people liked to do, eat, drink or wear. People's personal histories and preferred activities were not recorded in sufficient detail to inform staff. We made a recommendation regarding this.

The management team was supported by a contracted management consultant. Each party held responsibilities in relation to the assessment of quality and safety and completed audits as required. However, none of the audit processes had identified the significant issues, omissions and errors found during the inspection. Where issues had been identified, for example with the non-operational fire doors, effective action had not been taken to ensure people's safety.

There was no evidence of the provider being directly involved in monitoring the service. This meant that the provider did not have effective oversight of the Royal Oak Care Home and was primarily reliant on information generated from within the service. We found a breach of regulation regarding this.

The staff that we spoke with understood their individual responsibilities and knew what was expected of them. They told us that they enjoyed their jobs and were motivated to provide good quality care.

People and their relatives spoke positively about the attitude and approach of the staff and the quality of care. We observed the provision of care throughout the inspection and saw that staff treated people with dignity and respect.

People were given a good choice of nutritious food and drinks in accordance with their healthcare needs and personal preferences.

You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not always safe.

Medicines were not always safely managed in accordance with best-practice guidelines.

Some fire doors did not operate correctly and other areas of the building required remedial work to make them safe to use.

Risk in relation to personal safety and the provision of care was not adequately assessed, monitored and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not consistently trained or supported to provide safe, effective care.

The service did not always operate in accordance with the principles of the Mental capacity Act 2005.

The building was not well adapted to meet the needs of people living with dementia.

People had access to a good choice of food and drinks which were prepared to a high standard.

Is the service caring?

Good

The service was caring.

Staff interactions with people were positive and caring.

Staff took time to explain what they were doing and involve people in decisions about their care.

Visitors were made welcome and were free to visit at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments and care plans were not always sufficiently detailed to support the provision of safe, effective care.

Care records were lacking in person-centred information that reflected people's personal histories and preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audit processes had not been effective in identifying issues and concerns which were picked-up during the inspection.

There was no effective oversight of the service at provider level.

People spoke positively about the approachability of the management team.

Royal Oak Care Home

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 13 February 2017 and was unannounced.

The inspection team comprised two adult social care inspectors and a specialist advisor in nursing care.

Prior to the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We spoke with people using the service and their visitors. We also spent time looking at records, including five care records, four staff files, staff training plans, complaints and other records relating to the management of the service. We observed the delivery of care and the administration of medicines. We contacted social care professionals who have involvement with the service to ask for their views.

During our inspection we spoke with five people living at the home and seven visitors. We also spoke with the registered manager, the deputy manager, a nurse, a senior carer, the chef and two other members of staff.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we received information of concern which alleged that medicines were not being managed safely. Medicines were administered by trained nurses and senior care staff depending on the needs of the people. We saw evidence in staff records and medicine administration record (MAR) sheets that one member of staff had administered medicines prior to the completion of training and their competency being formally assessed. We spoke with the registered manager and deputy manager about this and were told that the person had completed training in their previous employment and that their competency assessment had now been completed.

We looked at the processes for the safe management of medicines within the service and spot-checked MAR sheets. We saw one incident where a medicine prescribed for pain relief was not administered as required because staff were 'awaiting prescription'. We saw that controlled drugs were not always safely managed. Controlled drugs are medicines with additional controls in place because of their potential for misuse. It is a requirement of the relevant guidance that records relating to controlled drugs are counter-signed to reduce the risk of errors. We saw that the stock levels relating to one controlled drug were incorrect and that the error had been brought forward from the previous page. This meant that the drug may not have been available when required because records indicated that more was available than was actually in stock.

MAR sheets were not stored consistently meaning that it would be difficult to review the records. We saw that MAR sheets were stored in different places. For example, a drawer in the nurse's station, loose in a filing cabinet and in document wallets in a filing cabinet.

The temperature of one of the rooms where medicines were stored was regularly recorded as 26 degrees Celsius. The recommended upper temperature for the majority of medicines is 25 degrees Celsius. The operating temperature of the medicines refrigerator was within a safe range. However, it was only recorded once per day when the instructions to staff required two temperature readings per day. If medicines are not stored properly they may not work in the way they were intended and so pose a potential risk to the health and wellbeing of the person receiving the medicine.

This is a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On an escorted tour of the service we were alerted to uneven floors on the first and second stories. There was significant bowing of the floors in a number of areas which created a risk for people, especially those with mobility difficulties. The registered manager told us that this was due to settlement within the building and was scheduled for repair.

Prior to the inspection we received information of concern alleging that a fire door did not function properly. As part of this inspection we assessed the functionality of fire doors throughout the service. We saw that two fire doors did not function correctly meaning that they would not be effective in reducing the spread of fire. For example, the twin fire doors leading to the kitchen did not fully close when the extractor fan was in use

and a fire door on one of the stairwells did not fully close. We reported these concerns to the registered manager who immediately contacted the contractor for the building. We were told by the contractor that the repairs would be completed within 48 hours. We subsequently checked that the repairs had been completed as scheduled. The registered manager told us that they had not and that a further request had been made to complete the outstanding work.

This is a breach of Regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk was not consistently and safely managed within the service. Risk assessments lacked detail and the files themselves were not presented in a consistent order which made it more difficult to locate important information.

Prior to the inspection we had received information of concern which alleged that people were not adequately protected from the risk of harassment. In particular, one person living at the service was regularly entering the rooms of other people and causing distress. We looked into this allegation as part of the inspection process. One person living at the service told us that another person had entered their room in a state of undress on more than one occasion. The person was clearly distressed by these events. The person's relative confirmed that similar allegations had been reported to staff, but that they were unaware of the issue at the time of the conversation. We spoke with the registered manager and other staff about the concerns and were told that measures had been taken to reduce the risk of a re-occurrence of the behaviour. The person had been moved to a room which was closer to the nurse's station/office so that staff could observe their movements more effectively. A referral had also been made for a formal assessment of the person's behaviour.

We had also received information of concern that people with dementia and complex behaviours and were not routinely separated from other people living at the service. It was alleged that this had led to a number of incidents where people were 'wandering' into the rooms of people being cared for in bed causing them distress. We spoke with the registered manager about this and they confirmed that those people with dementia and complex behaviours were now accommodated on a separate floor within the building to assist staff to observe and provide effective care.

Other information of concern focused on the management of risk in relation to fluid intake. We looked at the care records to check how fluid intake was monitored. We saw that records were incomplete and in some cases clearly indicated that people had not received their recommended daily intake of fluids. Where this was the case, no actions were recorded to reduce the risk going forward. We spoke with the registered manager about these concerns and were told that the service had recently replaced an electronic recording system with a paper-based one to improve the completeness and accuracy of recording. We noted that some of the records that we were referring to were recent and paper-based. A failure to effectively monitor and manager fluid intake for vulnerable people places them at risk of avoidable harm.

We saw examples where the information in the pre-assessment information had not been correctly carried through to the actual risk assessments for that person. For example, one pre-admission assessment stated that the person was doubly incontinent, yet the risk assessment for continence had been completed to show that the person was only incontinent of urine. We also saw information in the care record which stated that the person was 'continent when taken to the toilet.' This meant the information was confusing and incorrect which could lead to inappropriate care being given. In another example the person was recorded as needing 'total help with eating and drinking'. However it was also recorded that person 'needed finger foods'. So it was very unclear how the person was supported to eat and drink and whether the person was at

risk choking. There was no risk assessment regarding choking for this person.

There was a risk assessment in place regarding a person's skin. The person was turned and had barrier cream applied, however documentation showed that there was a skin break. However, this was not documented other than in the turn chart and had not been recorded in the handover information. The registered manager stated that the district nurses would keep that information. It is reasonable to expect an audit trail detailing the action taken from when the skin break was found including instructions for care staff.

Some people were not getting care as defined in their care plan. For example, for one person, we saw that they were at risk of weight loss. The care plan stated that the person needed to be weighed weekly. When we checked we saw weight recordings were eleven days apart in one instance and despite this and the family expressing concern, they were not weighed again until two weeks later.

This is a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives that we spoke with told us that the service was safe. However, some family members had only recently moved to Royal Oak Care Home and so families had only a limited time to assess their safety. One relative said, "[Family member] has only been here a week. [Family member] has been safe and well looked after." Another relative told us, "I've no concerns about safety, but [family member] did tell us there was a naked man in her room last week. It upset her."

Staff had been safely recruited and were deployed in sufficient numbers to provide safe, effective care. However, in some of the staff files that we saw references only contained the dates when they had worked for a previous employer and did not make comment regarding their conduct or suitability for the role. We spoke with the registered manager about this and they said that they would consider developing procedure to require an additional character reference in such circumstances. Staff were recruited subject to the receipt of a disclosure and barring service (DBS) check. A DBS check provides evidence that a person is suited to working with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

Staff were not supervised in accordance with the provider's policy. Staff told us that they were given informal supervision on a regular basis and that this was sufficient. However, records relating to formal supervisions indicated that meetings had been held with only two staff since October 2016. It would be reasonable to expect that new staff working in a recently registered service would receive regular, formal supervision to ensure that they were performing to an acceptable standard and receiving guidance and support in their roles.

Training was a mixture of e-learning and classroom based activity. Staff were trained in subjects relevant to their roles including; moving and handling, adult safeguarding and first aid. However, the records relating to training were unclear. The registered manager told us that some training was not recorded on their database due to a problem with the system. Other evidence that the training had been completed was not provided. Courses such as manual handling were facilitated by an external training company. Two of the senior carers had completed medication training in January 2017. However, one senior carer had completed their competency assessment before this date while the other carer did not have a competency assessment on record. We spoke with the registered manager about this and were assured that the assessment had been completed and that the other staff member had completed medicines training prior to their assessment. Evidence of this was not provided during the inspection.

Induction training was provided in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning, be observed by a senior colleague and be assessed as competent within 12 weeks of commencing their role. However, some records showed that the process had not been completed within the 12 weeks without good cause.

We recommend the provider reviews its arrangements for the training and supervision of staff to ensure they receive sufficient guidance and support to deliver safe, effective care.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Capacity was only assessed on a generic basis with no consideration of people's capacity to consent to specific aspects of their care. Not all staff had been trained in the MCA as required by the provider. The records that we saw did not clearly demonstrate that the home was operating in accordance with the MCA. For example, there was no capacity assessment in place before one DoLS application had been made to

local authority, so we did not know what the person was being assessed for. There was also confusing information in the person's care plan with regards to capacity which included that the person could say 'yes' and 'no'. However, the assessment also stated that the person had no capacity to choose their meals due to a 'high level of cognitive impairment'. There was no consent to the provision of care recorded. In addition, the person had bed rails in situ and there was no MCA or best interest process in place for this.

We recommend that the service reviews its practice in relation to the MCA and DoLS to ensure that it operates in accordance with the principles of the act.

Although the service had been designed to meet the needs of people living with dementia there were no obvious signs of appropriate adaptations. For example, accessible signage to help people to use the building more independently, or objects of reference to assist them in identifying their own rooms. The registered manager acknowledged that work was required to improve the building for people living with dementia and shared plans to install improved signage.

We recommend that the service reviews the design and décor of the building to ensure that it meets the needs of people living with dementia.

Prior to the inspection we received information of concern relating to the provision of food for people who required a soft diet. We asked about this provision and looked at the menus. The chef and other staff explained that people had a comprehensive range of options which included provision for those requiring a soft or pureed diet. We were provided with examples of the alternatives such as; mashed vegetables and soups. People told us that they enjoyed the quality and choice of food available to them. One person said, "The food here is beautiful. I couldn't fault it." While another told us, "I don't like fish, so I asked for steak. It's lovely." We sat with people and shared a lunchtime meal. The meal was served in a well-presented dining room with modern furnishings, table-cloths and matching cutlery and crockery. We saw that people had chosen different meals based on their personal preferences. Each meal had been prepared to a high standard and was nutritionally balanced. Hot and cold drinks were offered with the meal and served throughout the day. Staff were available to monitor and support people with their meals as required.

People were supported with their healthcare needs by the nurses and through contact with community based healthcare services. District nurses were in regular attendance and referrals were made to other community based services as required. However, some healthcare referrals were not clearly evidenced within care records. For example, one record contained a recommendation to contact a specialist team regarding swallowing difficulties and dietary requirements. There was no evidence that the referral had been made, but there was a record of contact with the person's GP to have a food supplement prescribed. We spoke with the registered manager about this who said that they would ensure that the referral had been made as required and that records were completed to a higher standard going forward.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the attitude and approach of the staff and the quality of care. One relative said, "The care staff are lovely from what I've seen." While another commented, "The staff are really nice." A third person told us, "The care here is top-notch. The staff are wonderful. So friendly."

We observed the provision of care throughout the inspection and saw that staff treated people with dignity and respect. We observed staff interacting with people in a manner which was caring. They took time to speak to people and knew each person and their care needs. Staff explained what they were doing and what was planned. It was clear that care was not provided according to a strict timetable and people were able to request care as it suited them. One member of staff said, "If people refuse care we come back to them." We were provided with an example from earlier in the morning where someone had declined their breakfast because they wanted a 'lie-in'. The staff member told us that they arranged for the person to have their breakfast later in the morning.

We saw that people had choice and control over the way care was provided. Staff asked people's opinions and responded appropriately. Each of the people that lived at the home was able to advocate for themselves, or did this with the support of a family member. We were told that nobody was making use of an independent advocate at the time of the inspection. Staff knew how to support people to access independent advocacy if required.

People's privacy and dignity were promoted by staff and people told us that they felt respected. However, we reported on two occasions that confidential information had been left on the same nurses' station where it could be easily accessed by other people living at Royal Oak Care Home or visitors.

Staff told us that it was important that people living at the home were helped to maintain their dignity as their care needs changed. We were provided with an example of someone whose behaviours threatened to compromise their dignity. The staff member explained how the level of observation had increased and what actions staff took to assist the person. We were told that people were supported with personal care in their own rooms or in locked bathrooms. Each room had its own en-suite toilet and shower and bathrooms were equipped with Jacuzzi baths to aid relaxation and therapy.

Friends and family members were free to visit the home at any time. People had visitors throughout the inspection and it was clear that they felt comfortable and welcome in the service. The service had ample space and facilities to accommodate visitors including dining rooms, lounges and bedrooms. One visitor told us, "They [staff] make us welcome." While another relative said, "We can make a cup of tea. There's a lovely feel about the place."

Requires Improvement

Is the service responsive?

Our findings

Records relating to assessment and care planning were not consistently completed to an acceptable standard. This meant that people were placed at risk of receiving inappropriate or inadequate care. For example, one pre-admission assessment from November 2016 had nothing written on the front page except the name and the date. Other pages had no name or date included and religion, height and medicines were not recorded. In other examples we saw a communication care plan that made no reference to verbal communication and a sleeping care plan that made no reference to length of sleep, or normal sleep pattern. None of the care records that we saw had been signed as required by the provider to indicate their approval.

Other records associated with the care plans were confusing, lacking in detail and were not consistently completed. For example, one person was assessed as low risk for evacuation while the evacuation register recorded that the same person required a wheelchair, two staff and was medium risk. In another example, an infection care plan stated that a person had a diagnosed chest infection. It did not show that any evaluation took place before the stated review date one month later. There was no evaluation recorded on the computerised record showing if, or when the infection was resolved or how it was treated. A nutritional care plan stated, 'staff to be aware of likes and dislikes' but didn't describe what they were. The plan also required daily monitoring of fluid intake with an expectation of 1,500ml to be consumed. On one day, intake was recorded as 500ml, but there was no record of any action being taken as a result.

Out of the care plans for one person, only three had been reviewed. The reviews were documented on the computerised records for body temperature, skin care and medical conditions, but not those relating to other aspects of their care. The care plans primarily used by staff were paper copies, this means that up to date reviews were not stored with the care plans, but needed to be accessed on the computer, making up to date information disjointed and more difficult to find.

This is a breach of Regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Person-centred information was not consistently recorded in care files. The staff permanent staff that we spoke with knew people sufficiently well to meet their individual needs. However, one agency staff member told us that they relied on information from colleagues and had not read the care files. The files that we looked at contained limited or no information relating to what people liked to do, eat, drink or wear. People's personal histories and preferred activities were not recorded in sufficient detail to inform staff. This meant that they had limited knowledge of people and their preferences which could be used to help engage them in conversation or activities. In one example we saw that one of the initial assessments for a person who lived at the service stated that they wanted to be supported by female only carers, yet their care plan stated they didn't have a preference.

We recommend that the service reviews its records to ensure they contain sufficient detail to provide effective, person-centred care.

A range of activities were provided by the service and facilitated by care staff. The registered manager said that the service was in the process of recruiting an activities coordinator. Activities had been discussed at a family committee meeting in February 2017 and a new activity of a knitting club was recommended for development. We saw people engaged in singing and dancing in the ground floor lounge. Other people were occupied with watching TV or chatting with visitors. People told us that they were happy with the activities on offer. A family member said, "[Relative] did a sing-song last week. The [member of staff] kept getting me up."

The service had not received any formal complaints. However, we saw a record of an internal investigation which was classified as a complaint which had led to disciplinary action and re-training. People told us that they knew who to approach if they wanted to make a complaint.

The service had a 'Family Committee' which met to discuss matters of importance. The committee last met in February 2017 and discussed; staffing, key workers, activities and development of the service. The meeting was attended by a total of 14 people using the service and their relatives. The service also issued professional advisor and visitor surveys. A small number had been completed and returned. Each contained positive comments.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place and was supported by a deputy and other senior staff. The deputy had only recently assumed management responsibilities because they had been deployed as a nurse until permanent staff were employed. The management team was, in turn supported by a contracted management consultant. Each party held responsibilities in relation to the assessment of quality and safety and completed audits. However, none of the audit processes had identified the significant issues, omissions and errors found during the inspection. Where issues had been identified, for example with the non-operational fire doors, effective action had not been taken to ensure people's safety.

Internal audit processes covered; house-keeping, administration, human resources and care plans. Action had been identified during the care plan audit, but had not been completed. Audit forms for maintenance and safety/security had not been completed. There was no record of fire drills or evacuations since the service opened in October 2016.

The role of the contracted management consultant was unclear. The registered manager told us that they visited regularly and were available for telephone consultation, but they did not complete a formal audit of quality and safety processes. There was no evidence of the provider being directly involved in monitoring the service. This meant that the provider did not have effective oversight of Royal Oak Care Home and was primarily reliant on information generated from within the service.

This is a breach of Regulation 17 (2)(a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke at length with the registered manager throughout the inspection. The registered manager understood their responsibilities in relation to their registration and had submitted notifications appropriately. They responded openly and honestly to the issues raised and requested support from the provider to rectify some of the concerns before the end of the inspection. However, on speaking with them subsequently, it was apparent that their requests for support had not resulted in the response required to keep people safe. It was not clear that they had access to the resources and support required to generate the improvements necessary to provide safe, effective care.

The manager was aware of the day to day culture within the service and was visible throughout the inspection. People told us that the registered manager was supportive and approachable. A relative commented, "The manager and deputy are very approachable."

The staff that we spoke with understood their individual responsibilities and knew what was expected of them. They told us that they enjoyed their jobs and were motivated to provide good quality care. One member of staff said, "I still enjoy the job. The atmosphere is laid-back. We're laughing all the time." While another recently appointed member of staff commented, "Expectations are clear. I'll be going through care plans to get to know people."

The service was only recently opened and was still in the process of developing systems and process, but most people spoke positively about the quality of communication within the service. A member of staff said, "Communication has been good." However, one relative said, "We don't get kept informed, but [family member] has only been here a few weeks."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed in accordance with best-practice guidelines. Some fire doors did not operate correctly and other areas of the building required remedial work to make them safe to use. Risk in relation to personal safety and the provision of care was not adequately assessed, monitored and recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Assessments and care plans were not always sufficiently detailed to support the provision of safe, effective care. Audit processes had not been effective in identifying issues and concerns which were picked-up during the inspection. There was no effective oversight of the service at provider level.