

Fylde Care 2004 Ltd

Glen Tanar Rest Home

Inspection report

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Blackpool
Lancashire
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Tel: 01253352726

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14 March 2018

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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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 12 and 14 March 2018, and was unannounced on the first day.

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

Glen Tanar Rest Home is registered to provide accommodation for up to 21 people who require 24-hour care. At the time of our inspection, 19 people were living at the home. The premises are an adapted house in Bispham, near Blackpool. Accommodation is provided over two floors, with a through-floor lift and stair-lift for access between floors.

At the last inspection in September 2015, we found the provider was meeting all legal requirements. At that inspection, we rated the service 'Good'.

During this inspection, we found the provider was not meeting all legal requirements and have rated the service 'Requires improvement'.

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

The provider had not ensured written plans of care were in place, in order to guide staff to deliver safe and effective support which met people's needs and reflected their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The lack of written plans of care was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection, we received confirmation from the provider that they had begun work to implement new care planning documentation in order to address this shortfall. You can see what action we told the provider to take at the back of the full version of the report.

The provider's systems to assess, monitor and improve the service had not been effective in identifying the concerns we raised during our inspection. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We looked at how the service managed medicines. Staff who administered medicines had all been trained to do so safely. However, we found information to guide staff on the use of 'when required' medicines was not in place and handwritten entries on medicines administration records were not countersigned, in line with best practice guidance. We have made a recommendation about this.

Staff had received training in relation to infection control and were aware of their responsibilities. However, we found communal toiletries were being used, which was not in line with best practice. We have made a recommendation about this.

Staff had assessed risks to individual people and risks posed by the environment. However, these had not been kept under review and updated accordingly. We have made a recommendation about this.

We received mixed feedback about meal provision. We saw meals looked appetising and were well presented. People raised concerns about the variety of choice on offer, particularly in the evenings. We found monitoring of people's food and fluid intake was not consistent. We have made a recommendation about this.

People who used the service or, where appropriate, others acting on their behalf, were involved in planning people's care at the initial assessment stage. However, people told us they were not involved in regular reviews of their care. We have made a recommendation about this.

We found confidential personal information was not always stored securely when not in use. We have made a recommendation about this.

People told us they felt safe living at the home. The provider had systems to protect people against the risks of abuse or unsafe treatment. Staff we spoke with were aware of procedures to follow in order to help people to keep safe.

The service followed a robust recruitment process which helped to ensure only people of good character were employed to work at the home. The provider ensured sufficient numbers of staff were deployed at all times.

Staff had received training around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. The service recorded people's consent to care and treatment. Staff confirmed they supported people to make their own choices.

The service sought guidance and advice from external professionals when necessary, in order to ensure people's ongoing health needs were met. The service shared information with other organisations when necessary, to ensure people's needs could be met effectively.

People's needs were met by a well-established and trained staff team. Staff received a good level of support from the management team.

People we spoke with told us staff were kind and caring. Staff respected people's privacy and dignity. People were treated as individuals and enabled to maintain as much independence and control as possible.

The provider had a complaints policy. People knew how to make a complaint or raise concerns and felt they would be listened to. People told us they felt any concerns would be dealt with appropriately.

The service addressed people's wishes and preferences for care at the end of their life. Staff had received training in order to provide people with a good standard of care in their final weeks and days.

A variety of activities were provided for people who lived at the home. The home took steps to try to meet people's individual needs. People we spoke with told us day to day activities could be improved. The

provider assured us they would look into this following our inspection.

People we spoke with and staff told us they felt the home was well-led. They told us the registered manager was approachable and willing to make time to listen to people.

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.

Staff were trained to administer medicines. However, best practice guidance had not always been followed in relation to handwritten entries.

Best practice guidance had not always been followed in relation to the use of communal toiletries.

The provider's systems around fire safety required review to ensure they were in line with best practice guidance.

The provider had ensured a sufficient number of staff were deployed at all times in order to meet people's needs safely.

The provider had systems to protect people against the risks of abuse or unsafe care.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The provider had not ensured people's preferences were taken into account with regard to meal provision.

People's food and fluid intake was not always monitored consistently where there was a need.

People were supported by a well-established staff team who received a good level of training and support.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People and, where appropriate, others acting on their behalf were not always involved in reviews of care.

The provider had not ensured confidential personal information was always stored securely when not in use.

People's privacy and dignity was promoted by staff who were kind, caring and compassionate in their approach.

Staff knew people well, including their social histories and preferences.

Is the service responsive?

The service was not always responsive.

People's needs were assessed however written plans of care were not in place to ensure the care delivered met people's individual needs.

The service had a complaints policy. People and their relatives were confident any complaints would be dealt with appropriately.

The service provided a variety of activities to try to ensure people's social health was maintained.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

The provider had systems to monitor the quality of the service provided and to seek the views and experiences of people who received a service. However, these systems had not identified the shortfalls we raised during this inspection.

Checks to make sure the premises and equipment were safe had been carried out.

There were clear lines of responsibility and accountability within the service. The staff team received a good level of support from management.

Requires Improvement ●

Glen Tanar Rest 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

The service is registered to provide accommodation for up to 21 people who require 24-hour care. At the time of our inspection, 19 people were living at the home. The premises are an adapted house in Bispham, near Blackpool. Accommodation is provided over two floors, with a through-floor lift and stair-lift for access between floors.

As part of 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.

This inspection took place on 12 and 14 March 2018, and was unannounced on the first day.

The inspection was carried out by an adult social care inspector, an inspection manager 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. The expert had personal experience of caring for older people.

During the visit we spoke with a range of people about the service. They included nine people who lived at the home and five visiting relatives. We also spoke with the registered provider, the registered manager, five care staff and the chef. We gained feedback from two visiting healthcare professionals. We also observed care practices and how staff interacted with people in their care.

We looked at care records of three people, the staff training matrix, personnel records of three staff and

arrangements for meal provision. We also looked at records related to the management of the home and medication records. We reviewed staffing levels and also checked the building to ensure it was clean, hygienic and a safe place for people to live.

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home and in the care of staff who supported them. One person commented, "I feel very safe here, the staff are lovely."

We looked at how the service managed people's medicines. Medicines, including controlled drugs were being obtained, stored and disposed of appropriately. Random sampling of people's medicines, against their medicine records confirmed they were receiving their medicines as prescribed by their GP. We discussed management of medicines with senior staff. They described the process they followed in relation to receipt, ordering and disposal of medicines. We found the systems they operated helped to ensure the proper and safe management of medicines.

Comments we received from people about medicines management included, "My medications are taken care of by the staff. I know my tablets and they always are correct." And, "The staff look after my medication and prescriptions. I have never been without tablets."

However, while reviewing medicines administration records (MARs), we noted there were no documented protocols for medicines prescribed for use 'when required'. We discussed this with the registered manager and a senior member of staff. They explained most people who were prescribed medicines for use 'when required' could tell staff whether they needed them. There was, however, one person who could not. The senior member of staff explained that staff knew when this person needed their medicines and how much, based on how the person presented. However, this information was not recorded in order to guide staff and provide consistency. Additionally, whilst reviewing MARs, we saw hand written entries had not been countersigned by another member of staff. This was not in line with best practice guidance and could have led to medicines not being administered appropriately.

We recommend the provider reviews their medicines policy and processes to ensure they are in line with best practice guidance.

Staff had received infection control training and understood their responsibilities in relation to infection control and hygiene. We observed staff making appropriate use of personal protective clothing such as disposable gloves and aprons. This meant staff were protecting people who lived in the home and themselves from potential infection when delivering personal care and undertaking cleaning duties. However, we found communal toiletries were being used, which was not in line with best practice. The use of communal toiletries can lead to the spread of infection between people who use them.

We recommend the provider reviews their policies and procedures related to infection prevention and control, in order to ensure they are in line with best practice guidance.

We looked at how the provider assessed and managed risks to people's health and well-being. As part of this, we looked at risks related to fire and potential evacuation of the home. We found the provider had undertaken a fire risk assessment and had plans in place to guide staff in the event of an evacuation.

However, the fire risk assessment had not taken into account the use of wedges to keep doors open. We also saw individual personal emergency evacuation plans (PEEPs) had been drawn up for each person who lived at the home, but these had not been reviewed and kept up to date. Additionally, when we spoke with staff and the registered manager, it was confirmed no practice evacuations had taken place. This would help to ensure staff understood their responsibilities if ever the home needed to be evacuated. We discussed these points with the registered manager and provider who assured us they would review their systems following the inspection.

We recommend the provider seeks guidance from a reputable source and reviews their systems around fire safety to ensure they are in line with best practice guidance.

The service had procedures to minimise the potential risk of abuse or unsafe care. Staff had received safeguarding training and were able to describe good practice about protecting people from potential abuse or poor practice. Staff we spoke with were aware of the service's whistleblowing policy and knew which organisations to contact if the service didn't respond to concerns they had raised with them. Staff told us they would not hesitate to raise concerns if they witnessed abuse or poor practice. The service's policies and procedures took into account the need for respecting people's human rights and emphasised people were not to be discriminated against with regard to any protected characteristics under the Equality Act 2010. The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.

We saw each person had individualised risk assessments which, for example, covered areas such as mobility, nutrition, pressure areas and physical health. We saw evidence the risk assessments were reviewed on a monthly basis, or when someone's needs changed. Staff we spoke with were able to describe confidently the steps they took to reduce risks to people. For example, referring people to external healthcare services for guidance and advice, as well as monitoring people carefully, when required. However, we found information to guide staff about how to lessen risks to people was not always recorded in detail. We discussed this with the registered manager and the provider during the inspection, who agreed with our findings. Following our inspection, we received confirmation from the provider that new documentation was being introduced to address this shortfall.

We looked at how the provider ensured a sufficient number of staff were deployed at all times. People told us and we could see for ourselves that there were enough staff available to meet people's needs and to keep them safe. We observed staff were able to take time to sit and talk with people in their bedrooms and in communal areas. As we walked around the building, we checked how quickly staff responded to call bells in people's rooms. We pressed the call bell three times and found staff responded quickly each time. We discussed staffing levels with the registered manager and the provider. They explained staffing levels were assessed through observations and discussion with staff on an ongoing basis. If extra staff were needed, the provider told us they would have no hesitation in increasing staffing levels.

We reviewed documentation related to the recruitment of staff. We found the provider had carried out checks to ensure staff were suitable to work with people who may be vulnerable. This included checks with the Disclosure and Barring Service as well as references from previous employers. This showed the service followed a safe recruitment process.

We looked at how the service recorded and analysed accidents and incidents. The registered manager showed us their systems which recorded details of such events, along with details of any investigations they had carried out. We saw the emphasis was on learning from any untoward incidents, in order to reduce the risk of recurrence.

Is the service effective?

Our findings

People who lived at the home and visiting relatives told us people were looked after well, by staff who knew how to care for them. Comments we received included, "I am independent but the girls [staff] help me if I need them." And, "I look after myself but I can always ask for help if I need it." A visiting relative told us, "All my [relative]'s care is done for her and the staff are very patient with her. The staff are very good."

We reviewed people's care documentation which showed their nutritional needs were assessed and monitored on an ongoing basis. People's weight was monitored in line with their assessed need, in order to highlight and lessen any risks. The registered manager explained if they were concerned about someone's nutritional intake or weight loss, they would refer them to the appropriate healthcare professionals for guidance and advice. However, we found monitoring of people's food and fluid intake was not recorded or reviewed consistently. Entries of amounts were recorded in people's daily records, however, these were not consistent. Additionally, the registered manager confirmed the amounts were not regularly reviewed, in order to decide whether a person had received sufficient amounts to meet their needs.

We spoke with people who lived at the home and visiting relatives about food provision and received mixed feedback. One person told us, "I am a type two diabetic and it is managed well with my diet and medications." Another person said, "The food is quite good but I would like some choice. Evening can be a bit boring just soup sandwiches or something on toast." Whilst another person commented, "I am a vegetarian and the food is fantastic. I never know what is coming next."

We found meals appeared appetising and well-presented. The chef and staff we spoke with knew people's likes and dislikes. However, we were unable to see how people's preferences had been used to shape the food that was offered. Additionally, people we spoke with and staff confirmed the choice of evening meals was limited. This was due to the chef finishing their shift in the early afternoon, which meant care staff were responsible for preparing food of an evening alongside providing care and support for people. One visiting relative told us, "I brought mum in some fish for tea but was told they didn't have time to cook it."

We recommend the provider reviews meal provision and monitoring of food and fluids, where required, in order for people's preferences to be taken into account and to ensure people receive adequate nutrition and hydration.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had policies and procedures to assess people's mental capacity and to support those who lacked capacity to manage risk. Staff we spoke with had an awareness of the MCA and were able to explain how they supported people to make decisions about their day to day lives. People were able to choose what they wanted to do and were supported by staff. This was confirmed by people we spoke with. Where people lacked capacity to make decisions, this had been assessed and recorded. Staff followed a process to ensure decisions were taken in the person's best interests.

Care documentation the provider used had a section where people's consent to care could be recorded. We saw the documents were signed by people to say they gave consent, or, where appropriate, someone else acting on their behalf. However, we found the provider had not always ensured they had sight of legal documentation before allowing a person's relative to give consent on the person's behalf. We discussed this with the registered manager and provider during the inspection who agreed they would review their processes accordingly.

We saw documentation which showed people were supported to see other health professionals, as required. For example, we saw people were referred to doctors and district nurses if there was a need to do so. We noted care records were updated to reflect the health professional's advice. However, we found one instance where a person had been prescribed thickener for their drinks. The person's care documentation did not contain sufficient information to guide staff on its use and we were told conflicting information about how it was used. The registered manager contacted external professionals for advice during our inspection, to ensure they had accurate guidance for staff to follow. The registered manager explained information was shared with other organisations when necessary. For example, if someone was admitted to hospital, information about their current health and care needs was shared, in order for people to receive care that met those needs effectively.

We looked at each area of the home to make sure it was a safe and suitable environment for people to live in. The registered manager showed us around the building. The premises were clean and tidy. We reviewed the maintenance log for the home which showed ongoing work to maintain the premises. The through-floor lift had been inspected and maintained, however it had broken down on a number of occasions. We discussed this with the provider, who explained they had installed a stair lift as a contingency and would continue to repair the lift as required.

People received care from an established and trained staff team who had a good understanding of their assessed needs. We were able to establish through our observations people received care which met their needs and protected their rights. All staff had achieved or were working towards recognised care qualifications. This helped to ensure people were supported by staff who had the right knowledge, qualifications and skills to deliver care and support effectively.

Staff we spoke with told us and records we looked at confirmed staff received regular supervision sessions. These were a one-to-one meeting between senior staff and the staff member where performance and development was discussed. Staff we spoke with told us they felt well supported by the registered manager and senior staff.

Is the service caring?

Our findings

People we spoke with were complimentary about staff and their approach. One person told us, "I am independent but the girls help me if I need them." Another person said, "This home is fine. I am happy as I can be. The staff are all warm and friendly. I look after myself but I can always ask for help if I need it."

We looked at how the service involved people or, where appropriate, others acting on their behalf in reviews of their care. We were unable to find any written evidence to suggest people were involved in reviews of their care. For example, one person told us, "When I came here the staff asked me what I like to do and made notes but I haven't been asked since." When we asked staff about involving people, we were told feedback was gained from people on an informal basis through daily conversations with staff. However, people or, where appropriate, others acting on their behalf were not involved in reviewing plans of care.

We recommend the provider seeks best practice guidance around involving people in decisions about their care and how the service is delivered.

We noted confidential personal information was not stored securely when not in use. Medicines administration records and daily care records were kept unsecured in the dining room of the home. This meant sensitive information about people was freely accessible.

We recommend the provider seeks best practice guidance around managing information.

We observed staff took a kind and caring approach when delivering support to people. For example, we saw staff patiently helped one person to walk while offering positive and reassuring comments. We observed and staff told us they had time to spend with people on a one-to-one basis each day. During our observations, we noted many positive interactions between people who lived at the home and staff; lots of smiles, hugs and laughter.

During the inspection we saw staff respected people's privacy when delivering care and support. For example, we observed bedroom and bathroom doors were closed when personal care was delivered. People who lived at the home confirmed this took place and told us they felt staff respected them and helped to preserve their dignity.

Staff had received training around equality, diversity and human rights. Staff we spoke with told us the ethos at the home was to treat each person as a unique individual. This showed the provider had regard to ensuring staff upheld people's rights and people were not discriminated against when receiving a service. This was in line with legislation such as the Human Rights Act 1998 and the Equality Act 2010.

The registered manager explained they spent time during initial assessments to assess people's communication needs so they could ensure people understood information to make informed choices. The registered manager also explained how they would ensure people with communication difficulties, such as poor eyesight or poor hearing would be supported so they could access information.

We discussed the provision of advocacy services with the registered manager. They explained one person had an advocate who was involved in making decisions on the person's behalf. If other people needed or wanted an advocate, the registered manager confirmed they would help people to access such services. This showed the service supported people to access external services to act on their behalf if and when required.

Is the service responsive?

Our findings

People who lived at the home and visiting relatives told us they received care and support that met their individual needs. This was with the exception of activity provision, which people and their relatives told us needed improvement. Comments we received from people included, "This was my choice and I am happy here." And, "The home fits in with my needs. I am a very late riser and no one minds. I have my books and phone which keep me occupied." One person told us their main complaint was the lack of activities. Another person gave us similar feedback, saying, "I would like to have more activities laid on by the home. Someone comes once a month to play the piano and we have a do on Valentine's Day or Christmas but there is nothing on a day to day basis."

We looked at care documentation which included assessments of people's needs. However, the provider had not ensured written plans of care were in place, in order to guide staff to deliver safe and effective support which met people's needs and reflected their preferences. Staff we spoke with were able to describe individual people's needs and preferences in relation to how care was delivered, however these had not been recorded. Following our inspection, we received confirmation from the provider that they had begun work to implement new care planning documentation in order to address this shortfall. This was in breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additionally, the lack of written plans of care was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

We looked at what activities the home provided in order for people who lived there to receive stimulation and to maintain social health. People we spoke with, visiting relatives and staff all told us about events such as a Christmas party and the 'music man' who visited the home each month to provide entertainment. However, everyone we spoke with also confirmed there was very little provision in terms of activities on a day-to-day basis. One person told us, "I used to play pool and darts but can't do either now. I would like more to do in the day." The provider had recently purchased a table-top pool table in order to try to meet this person's needs. This showed the service tried to meet people's individual requirements around activities.

A relative we spoke with told us they had arranged for their family member to move to the home over 18 months ago, because they wanted more activity and stimulation. However, they told us this had not been the case, "Since [family member] arrived she has not even been taken for a walk. There are no activities provided on a regular basis, just occasional trips and sometimes a sing - song."

During the course of our inspection, we observed what activities took place in the home. We observed staff spent time chatting with people and two people were playing dominoes in the afternoon. Another lady was busy doing puzzles when we approached her.

We discussed activities with senior staff and the provider. They told us the service employed a dedicated activities coordinator who attended the home on a Tuesday and Thursday and that they took people out of the home. In addition, they showed us information relating to other events and explained how they tried to meet peoples' needs in terms of activities and social stimulation. Events and activities that had taken place included trips out to Blackpool Pleasure Beach, outings to the beach and garden centre, attending local school plays and themed events at the home, such as a 60s & 70s night. Various other activities and events had taken place.

The provider and registered manager felt the service provided a varied activity programme and, as such, day-to-day activity provision had not been identified as an area for improvement. They assured us they would explore this following our inspection feedback.

We saw care documentation which showed end of life care had been discussed with some people who lived at the home. This helped to ensure their wishes for their final days were recorded so they could receive the care and support they wanted at that time. We looked at the service's training matrix which showed staff had received overview training in end of life care. We spoke with two people whose loved one had recently been receiving end of life care at the home. Feedback from them was complimentary in every aspect. Comments included, "My [relative] was very happy here. The home is excellent. They were continually in and out of mum's room during the last days. The staff cared really well for my mum. When I came to be with mum I was fed and cared for too. [Registered manager] asked for help from the hospice to look after mum in the last days."

The provider had a complaints procedure, which described the response people could expect if they made a complaint about the service. Staff we spoke with told us they would assist people in making a complaint if required and would raise and concerns with the registered manager. This showed there was a clear process to handle complaints. People we spoke with had not raised any complaints but told us they felt any concerns would be addressed. The provider had not received any formal complaints since our last inspection.

Is the service well-led?

Our findings

People we spoke with, visiting relatives and staff all told us they felt the service was well-led. Comments we received included, "I think we have a good team here. I feel well supported." And, "I know if we needed anything we would get it and if we want to develop, we just need to ask." We received positive feedback about the registered manager and the provider, both of whom were described as approachable, easy-going and accommodating. Staff members we spoke with told us they would have no concerns in approaching senior staff with concerns and were confident they would be dealt with appropriately.

We looked at what systems the provider had to assess, monitor and improve the service provided. We found a range of audits and checks were in place. These covered areas such as risk assessments, care planning, fire safety and medicines. On reviewing audits, we saw some shortfalls had been identified, but we could not see what action had been taken to address them. When we looked at care plan audits, we saw they had not identified any shortfalls relating to the lack of written care plans. We discussed this with the registered manager and provider who assured us they would seek guidance around best practice with regard to these systems.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's systems to assess, monitor and improve the service had not been effective in identifying the concerns we raised during our inspection.

Staff we spoke with all told us the management team were visible, supportive and available to provide guidance and advice. The registered manager spent time working alongside staff to monitor the culture and performance of staff. Staff felt they were involved in shaping how the service was delivered and could make suggestions or raise concerns at any time. Staff we spoke with were clear about their roles and responsibilities. This showed the service had clear lines of responsibility and accountability and the staff team were well supported by management.

The registered manager explained and records we looked at confirmed they worked with other agencies to ensure they were providing care in line with best practice. The registered manager explained they sought guidance and advice from external professionals including speech and language therapists, dieticians, district nurses and GPs.

The registered manager told us they encouraged and sought feedback on the service provided from people who lived at the home and relatives. We saw minutes of 'resident's meetings' which had taken place since our last inspection. The provider also used questionnaires to gain people's views about the service they received. However, we saw from minutes of the last residents' meeting in May 2017 that people said they would like meetings every two or three months and none had taken place since. In addition to formal methods, the registered manager spent time with people on a day to day basis to seek their views on the service they received. People told us they felt they could approach the registered manager at any time and she would make time to speak with them.

From the 01 April 2015 it is a legal requirement that the home conspicuously displays its last CQC rating. We noted this was available in the entrance area of the home.

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>The provider had not ensured written plans of care were in place, in order to guide staff to deliver safe and effective support which met people's needs and reflected their preferences.</p> <p>Regulation 9 (1) (2) (3)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider's systems to assess, monitor and improve the service had not been effective in identifying the concerns we raised during our inspection.</p> <p>Regulation 17 (1) (2)</p>