Blagreaves Care Home Limited

Windsor Park Nursing Home

Inspection report

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Littleover
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Tel: 01332761225

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 30 August 2017, and the visit was unannounced.

Windsor Park Nursing Home provides residential and nursing care to older people including people who are living with dementia. Windsor Park Nursing Home is registered to provide care for up to 19 people. At the time of our inspection there were 15 people living at the service.

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.

We last visited the home in February 2016. We found that the provider had to make improvements in safe, caring and well led.

On this visit we found that there were breaches in providing adequate infection control, effective systems were not in place to assess and monitor the quality of care and notifications. We found a number of infection control issues throughout the service and documents relating to people's health and safety were not managed or reviewed. Notifications which the provider is duty bound to send us had not been forwarded.

Staff understood the need to protect people from harm and knew what action they should take if they had any concerns. Staff understood their role in caring for people with limited or no mental capacity under the Mental Capacity Act 2005.

People were provided with a choice of meals that met their dietary needs. The catering staff were aware of people's dietary requirements, and people's opinions were sought about the menu choices in order to meet their individual dietary needs and preferences. Some activities tailored to people's interests were provided by staff and external professionals on a regular basis. Staff had had access to information and a good understanding of people's care needs. People were able to maintain contact with family and friends and visitors were welcome without undue restrictions.

Relatives we spoke with were complimentary about the managers', nurses and staff, and the care offered to their relations. People were involved in the review of their care plan, and when appropriate their relatives were included. Staff had access to people's care plans and received regular updates about people's care needs. Care plans included changes to peoples care and treatment and people were offered and attended routine health checks.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the service. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.

Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance contractors to manage any emergency repairs. The provider had a clear management structure within the service, which meant that the staff were aware who to contact out of hours if an equipment repair was necessary.

The provider carried out quality monitoring checks in the service supported by the deputy manager and service's staff. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service and their relatives.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were placed at risk from acquired infections, through poor infection control procedures.

Staff were employed in sufficient numbers to protect people and understood their responsibility to report any observed or suspected abuse. People said they were supported with their medicines, though the administration of medicines was not consistently secure. Potential risks to people's needs were managed and concerns about people's safety and lifestyle choices were discussed to ensure their views were supported.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff recording was inconsistent and placed people at risk of ineffective care.

Staff understood the requirements of the Mental Capacity Act 2005 and sought people's consent to care before it was provided. Staff had completed essential training to meet people's needs safely and to a suitable standard. People received appropriate food choices that provided a well-balanced diet and met their nutritional needs. People received health care services which were undertaken robustly to protect people from harm.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and treated people individually, recognising their privacy and dignity at all times. However some of the toilet and bathroom doors did not support people's privacy. Staff understood the importance of caring for people in a dignified way, and people were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's care records were not regularly or consistently completed to ensure people were cared for safely.

People received personalised care that met their needs. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People were confident to raise concerns or make a formal complaint where necessary.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not ensure an effective overview of the service and to take action to protect people as needed. Effective systems were not in place to assess, monitor and improve the records produced by staff.

There was a registered manager in post. People using the service and their relatives had opportunities to share their views and influence the development of the service.

Windsor Park Nursing 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.

This unannounced inspection took place on 30 August 2017 and was carried out by one inspector a nurse specialist adviser 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. Our expert by experience's area of expertise was the care of older people and those living with dementia.

Before the inspection visit we looked at the information we held about Windsor Park Nursing Service including any concerns or compliments. We looked at the statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the service.

The registered manager, deputy manager and nurse assisted us on the inspection. We asked them to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the service following our last visit. We also received information from them following the inspection visit.

Some of the people living at the service were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with five people and four relatives to gain their experiences of living at, and visiting, Windsor Park Nursing Service. We also spoke with the registered manager, deputy manager, nurse on duty, two care staff, and the cook.

We looked at four people's care plans and records to see how they were cared for and supported. We looked at other records related to people's care such as risk assessments, medicine records and notes of day to day care provided to people. We also looked at staff recruitment and training records, quality audits, records of complaints, incidents and accidents and safety records.

Requires Improvement

Is the service safe?

Our findings

When we spoke with people about the cleanliness of the service one relative said, "The dining chairs could do with a wipe, if you run your hands down the chair it's sticky. Same with the lounge chairs they could do with a good clean."

There were no adequate arrangements for keeping the service clean and ensure that people were protected from acquired infections. We saw there had been an 'environment check' that had been completed by the registered manager. That highlighted some potential infection control risks, where some of the dining chairs had torn seats with the arms and frames dirty and sticky. However there had not been anything put in place to rectify these issues, for example a regular cleaning regime. We checked and found some seats were torn and still in need of repair. There were many chairs that were sticky and in need of being cleaned. There were wheelchairs which required cleaning as they also had a build-up of dirt and food deposits. We looked around the service and saw the sluice downstairs had a dirty sink and the sluice rack was stained, there was no liner in the bin and paint was flaking off the wall. That meant there was the potential for cross infection and cross contamination from the equipment and porous wall surfaces.

We also saw the toilet upstairs had no liner in the bin; the shower screen was dirty as was the skirting boards. Where the flooring in the laundry and some toilets was joined these had begun to separate, and had also parted from the skirting boards.

One of the bathrooms had a bath panel that was cracked and the bath hoist was not sealed to the floor. The provider had not produced cleaning schedules and no record of formal environment checks was available to view. That meant there was no formal instruction for staff to clean and disinfect areas of the environment which placed people at risk in the service. This allowed dirt and dust to accumulate in these areas which posed a threat from cross infection or cross contamination.

This was a breach of Regulation 12 (2) h of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment and transfer of infections.

People and their relatives we spoke with said care staff supported them with their medicines. Medication Administration Records (MARs) were in place for each person and detailed with a photograph and any allergy information. However not all MARs for people in receipt of 'as required' medicines (PRN) had instruction when, or under what circumstances staff should offer these medicines. There were also no separate charts for the application of prescribed pain relief patches, to ensure the areas were varied to minimise the potential for skin irritation. The MAR chart did not state where these should be applied only stating 'as directed' which did not ensure staff's awareness.

We found the accounting of medicines was not accurate and the balance of some medicines was not what was in stock. The inaccuracies found suggest that the checking processes were not robust. We spoke with the registered manager who said these would be tightened up to ensure absolute accuracy.

Some people were administered their medicines covertly. That meant they were included in food or drinks to ensure the person took the prescribed medicine, and this was authorised appropriately by the GP. However there were no best interests meetings to support this or evidence that this was only used as a last resort. There was no evidence that the advice of a pharmacist was sought as to the suitability to disguise medications in the manner proposed. There was no evidence of reviews of this decision, which would have considered if this was still an effective means for people to receive medicines this way. We spoke with the registered manager who said he would ensure the inclusion of these plans forthwith, and ensure the pharmacist was involved in the process.

Storage of medicines was secure, and staff monitored the temperatures to ensure they remained potent and effective. However, we found there were gaps in the records prior to our visit, where no room temperature had been recorded. We spoke with the registered manager, who said he would ensure daily checks would be completed, and there was a sufficient supply of medicines in stock and the disposal of medicines was safe.

People told us that they felt safe and staff cared for them safely. One person told us, "Yes I feel safe here. They [staff] are all very nice." A relative said, "Yes [named] is safe here."

Care staff felt that people were cared for safely and were protected from harm. Staff said they would report any concerns or suspicions of abuse to the registered manager or deputy. Staff were aware how to contact external agencies such as the local authority safeguarding team or Care Quality Commission (CQC) and said they would do so if they felt their concerns were not dealt with.

Staff had a clear understanding of the different types of abuse people could be subjected to. One member of staff said, "I know I can go to social services and possibly the police if needs be." The member of staff confirmed the agencies that people could be referred to in that event.

Staff told us they had received training on how people should be protected from abuse or harm. Staff were aware of their role and responsibilities in ensuring people were protected and what action they needed to take if they suspected abuse had occurred. Staff we spoke with were aware of whistle blowing, and said they had not seen anything that required reporting on in this way. They also knew which authorities outside the service to report any concerns to if required, which would support and protect people. The registered manager was aware of their responsibilities and ensured safeguarding situations were reported to the Care Quality Commission as required. The provider had a safeguarding policy and procedure in place that informed staff of the action to take if they suspected abuse.

Staff demonstrated their awareness of people's individual needs, and the support they required to stay safe. We saw people were offered the support detailed in their care plan and risk assessments. People's care records included risk assessments, which were reviewed regularly and covered the activities related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. Care plans provided guidance for staff in respect of minimising risk. A relative told us they were involved in discussions and decisions about how risk was managed.

The premises were generally safe but the decorating in the service required to be updated. One relative commented about this and said, "There could be improvements in the décor. If you look at the lounge ceiling you can see where it's peeling down." We spoke with the registered manager who explained a programme of redecoration was on-going and the lounge was planned to be decorated in the weeks following the inspection. We saw this written in the maintenance plan for the service.

We looked at people's personal evacuation plans (PEEPs). These tell staff how to safely assist people to leave the premises in an emergency. These were accessible to staff in the event of an emergency and copies were also kept in people's care plan file, and were reflective of people's current moving and handling needs. Staff told us they took part in regular fire drills so they knew what action to take in the event of an emergency, and were aware how to access the PEEPs.

We found staff were employed in sufficient numbers to protect people from harm. A visiting relative said, "Yes I think there's enough staff. There's always someone around in the lounge/diner where mum sits during the day."

We saw staff responded to people's needs and requests promptly. We spoke with the registered manager who explained the staffing numbers were adjusted to ensure a safe living environment for people. They provided an example where additional staff were placed on shift and provided care for a person with short term care needs. That meant the provider employed staff in sufficient numbers to care for people safely.

Staff confirmed there adequate staff to provide a safe service for people. In addition, there was the registered manager, registered nurse and catering staff. We confirmed these staff numbers were typical with the staff rota. We looked at three staff files and the staff recruitment records and found that the relevant background checks had been completed before staff worked at the service. This helped to ensure that only suitable staff worked at the service.

Requires Improvement

Is the service effective?

Our findings

People told us they felt the meals provided were good. One relative said, "They help [named] with the food when I'm not here, they choose for him. The food's very good, it's not the same every day. He always has plenty of drinks."

We found people were provided with a balanced and varied diet that helped maintain their weight. Records relating to nutrition and hydration were completed where people were at risk of weight loss or dehydration. We saw where people had been referred to medical professionals if there were concerns about their nutrition, and some had their food and drinks prepared in a special way to aid their swallowing. However the accuracy of records relating to people's fluid intake was poor. We saw some records had not been completed accurately with missing records and some not completed at all. We spoke with the registered manager who said he would remind staff about completing these and would ensure he checked the records regularly to ensure people were being given adequate fluids.

We also viewed a sample of records which were used to record people's position changes to ensure their skin was protected from damage such as pressure areas. All four records were incomplete and two had nothing recorded between 10 pm and 8 am the following day. We asked the registered manager about this and he assured us it was a recording error, as the records were completed on some occasions. He said he would take this up with the night staff concerned. The inconsistent approach by staff to completing these records accurately placed people at risk of skin deterioration and related infections.

We observed staff offer morning drinks to people and their visitors, and staff also offered snacks such as biscuits or fruit. There were jugs of juice available in the lounge and people were prompted to help themselves to drinks and those who were unable were assisted with additional drinks.

Menu preferences were discussed at regular 'resident and relative' meetings which were planned every two to three months. Discussions take place about people's likes and dislikes, outings activities and staff attitudes. Changes to peoples preferences were recorded in their care plans, which were available to staff. This information included any food allergies and was also made available to catering staff. The staff were able to explain what this meant for people, and how the information was used. That helped to ensure meals prepared were suitable for everyone.

People had the choice to eat in the dining room, lounge or their bedroom. People were assisted to choose meals by staff that provided a verbal choice before lunch, and then presented people with a choice of plated meals when the meal was served. Four people had relatives visiting and assisted them with their lunch time meal. We observed another two people who were being assisted by staff. The members' of staff were positioned to help them effectively. They described the meal to people and enquired if the temperature and taste of the food was to their approval. This demonstrated staff were able to communicate with people, promoted choice and supported people to eat their meal.

People looked relaxed throughout the meal and staff supported people to eat without rushing them. We saw some people required prompting to eat their meal. Staff were attentive and responded to requests, for example where people wanted assistance with cutting their food into smaller pieces and providing further drinks. We saw all staff maintained relaxed conversations with people throughout the meal.

We saw people's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) and the dietician. This ensured any changes to people's dietary needs were managed in line with professional guidelines. Some people were recorded as having a poor appetite. Records showed how much the person ate and drank to ensure they had sufficient to maintain their health.

People and their relatives told us they were happy with the staff that supported them. They told us staff understood their needs and how they liked to be cared for. We observed people were offered the support detailed in their care plan and risk assessments.

Staff told us that they felt they had enough training and felt they had no gaps in their knowledge. Staff commenced their training with an induction programme and then had access to courses relating to their role in health and safety, manual handling and food hygiene and infection control. We confirmed the induction programme by speaking with and looking at the records of a recently commenced care staff.

We saw the training records which showed that all staff had updated essential training. The registered manager said the training matrix was current and was used to inform the management staff when further training was required. We also saw that staff had been provided with specialist training around allergies, food hygiene and swallowing difficulties.

People's consent to care and treatment was sought in line with legislation and guidance. We heard people being asked for consent to care before this was undertaken. We heard staff asking one person, "Hello [person's name] I have your tablets [medicine] here, would you take them for me?" The person agreed and the member of staff proceeded to administer the person's medicines. We also heard staff asking people for similar consent throughout our visit, for example people were asked if they were willing to be assisted with personal care.

Records showed that people who used the service had mental capacity assessments in place with regard to making certain choices and decisions. When people lacked capacity to give their informed consent, the law required registered persons to ensure that important decisions were taken in their best interests. A part of this process involved staff consulting closely with relatives and with health and social care professionals who know a person and have an interest in their wellbeing. We also saw where one person had arranged a Lasting Power of Attorney (LPA) prior to being admitted to the service. This document allowed one or more appointed persons' to help make decisions on behalf of the person.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 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 services are called the Deprivation of Liberty Safeguards (DoLS).

We found that the registered manager had ensured that nine people were protected by the DoLS. One relative we spoke with about this said, "She's had the DoLS [Deprivation of Liberty Safeguards] assessment and everything's fine, they assessed how she's being looked after, I got a copy of the report and all is fine." A second relative said, "I can't see mum making choices anymore…... She lets you know if she doesn't want something. When staff make decisions they're right for mum."

Records showed that the registered manager had applied for the necessary authorisation from the relevant local authority. Some people had been represented by a family member. They can represent the person's views to those responsible for making decisions about their care and treatment, and check those working with the person adhere to the main principles of the MCA and act as a safeguard for the person's rights.

When we spoke with care staff they recalled their training on MCA and DoLS and who was subject to a DoLS restriction. Care staff told us that they felt they would be able to recognise if a person's liberty was potentially deprived and required a DoLS application to be completed. Records we viewed confirmed that care staff had been trained in both the MCA and DoLS. One member of staff said, "I would take any concerns to the manager, I know she would act accordingly."

We saw there were daily handover meetings which provided staff with updated information about people's health and any changes to peoples care and treatment. Staff also told us they were supported through regular staff and supervision meetings with the registered or deputy manager. Staff supervision was used to support and check staffs' knowledge, training and development by regular meetings between the management and staff group. That benefited the people using the service as it helped to ensure staff were well-informed and able to care and support people effectively.

One relative said to us, "They [staff] will call the doctor if necessary, [named] had a bad chest and they called the doctor and was rushed into hospital. When [named] came back they looked after her well. They'll soon onto the Doctor to get her checked if they see anything." Another said, "We have the freedom to do as we want, we take [named] out to the dentist, hairdresser and chiropodist rather than leave it to the staff."

People were supported to maintain their health and wellbeing. People's relatives told us and care records demonstrated that people received effective health care support from a range of health care professionals such as GP's, specialist nursing staff, hospital consultants SALT and dentists. People were accompanied by relatives and staff to routine medical appointments.

Good

Is the service caring?

Our findings

Visiting relatives told us that staff were kind and compassionate and treated people living in the service with respect. A relative said, I think they are kind and caring staff." A second relative said, "[Named] is being well looked after I've no worries about that. He [the senior nurse] spends a lot more time with [named] he seems to be more experienced and can calm her down. He's now trying to get staff to sit with her before [her behaviour increases] to help them manage it."

We saw people were treated with kindness and compassion by a caring staff group. We observed staff interactions with people throughout the inspection which showed that staff were caring and helpful and people were treated with dignity. We heard staff asking people in a caring way if they required assistance by asking them, 'can I help you with that', 'are you comfortable', 'can I wash your face'. That demonstrated staff sought permission before offering care and attention to people.

We observed staff who assisted people to eat their lunch. We saw staff were seated at the correct height and maintained eye contact and conversed with the people at appropriate times throughout the meal. The staff also ensured people's clothes were protected from food spillages, which assured their dignity. That demonstrated staff took steps to promote people's dignity. However we saw that some of the toilet and bathroom doors did not lock, which did not ensure people had the choice to preserve their own dignity whist using these facilities. We spoke with the registered manager who said these door locks would be added to the maintenance schedule.

Staff knew people and the name they preferred to be called. Some people were unable to express their views and opinions. Records showed that family members had been involved in care plan reviews and there was information in care plans to ensure people were referred to by their preferred name.

The registered manager confirmed some people's relatives were involved in care planning and reviews though some care records were not signed by the individuals or a family member. The registered manager told us care plans reflected people's needs and were reviewed when changes took place or at least monthly. Staff confirmed people were asked to take part in care plan reviews but only a few of them chose to take part in this process. The registered manager added that relatives and close family members were informed when people's health or wellbeing changed.

Staff were observed to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively and were also seen to use distraction techniques to calm people. We later saw these care interventions written into care plans as one way of caring for people that were upset.

Staff were observed and overheard to knock on doors and identified themselves before entering rooms and staff doors closed when personal care was being offered. Staff responded to people's requests promptly, and were heard and observed to interact with people throughout the day. We saw where one person requested a shower late morning staff took her straight away. This again promoted the person's dignity.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt the staff had got to know people well since they had moved into the service. One relative said, [Named] always looks clean and tidy, she's happy and settled here. She knows the carers more than us three now. She's developed a bond with some of them, the way they speak to her you feel like they know her."

We looked at people's care plans and found they included pre-admission assessments, which identified each person's individual needs. Care planning was linked to people's needs which ensured care plans were individualised. We saw evidence of information on allergies, likes, dislikes, and past life histories completed by people and their families had been added to some care plans.

Staff had access to people's plans of care and received updates about their care needs through daily handover meetings. The care files we viewed were comprehensive, and revealed regular reviews of people's care, which demonstrated the care process was responsive to people's changing needs. Staff demonstrated their detailed knowledge of people's needs. One member of staff said, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right."

We saw some people were engaged in activities in the service. There was an activity plan in the lounge and dining area that indicated there was a choice of board games, gardening, and food tasting for the day of our inspection. We saw some people had been taken out into the garden and other staff attempted some games with people in the morning. We did not see the food tasting planned for the afternoon. We spoke with the registered manager who said the activity person was not on duty on the day of our inspection and they did more person centred activities for example hand massages and perfume and flower smelling to stimulate their senses.

We spoke with the registered manager about how activities were decided in the service. They said people were asked through the regular meetings for those in the service. We looked at the copies of the 'residents meetings' minutes which confirmed this. Suggestions from these included changes to the menu and increasing the heating in the service, where additional knee blankets have also been provided. Relatives were also asked to comment through the quality questionnaires that were sent out regularly. However none of the relatives we spoke with could remember asking for any changes to people's activities.

The registered manager said there was a flexible policy for visitors, with people being able to visit at most times including meal times. The registered manager said the only time people would be asked to wait was when the person was being assisted with personal care.

The provider had systems in place to record complaints. No one living in the service commented about the complaints process but one visiting relative said, "Yes they listen – I'd go to the owner if I had a problem." A second relative responded, "Yes they do listen and respond. I complained one day ….. now they've put a notice in their room." A third relative said, "They keep [named] clean and tidy I've got no complaints."

People we spoke with said they knew how to make a complaint, some said they would speak with a member of staff. The relatives we spoke were aware how to make a complaint, and were aware who to approach in the staff group to have these followed up. Records showed the service had received no written complaints in the last 12 months. The registered manager said that any complaints would be responded to in line with the services' policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found effective systems were not in place to assess and monitor the quality of care. We asked the provider about the quality assurance he undertook in the service, and he replied he did some daily checks. However, no audit systems were in place to assess and monitor the quality of the information and completion of the fluid balance charts or re-positioning charts. Information was recorded at some times and not others dependant on the staff on duty. These documents were not reviewed by the provider. That meant people were at risk of harm due to the lack of effective monitoring of associated care and health documents.

Similarly there was no infection control protocols to instruct staff how to properly clean and disinfect areas in the service. There were no cleaning schedules to instruct the staff how areas of the service should be cleaned and disinfected. There was no audit of repairs to the fabric of the building to ensure these had been completed which placed people at risk of harm. An infection control report had been distributed by the Clinical Commissioning Group (CCG) which is part of the NHS and local health services. We viewed the completed report but this did not reveal the extent of the issues in the service.

The provider had failed to make sure quality assurance systems were in place to ensure that records had been thoroughly monitored to protect people from harm and ensure their safety. This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had failed to submit some notifications. The provider had notified of us most events that affected the people and staff. However there was an outbreak of a transmittable infection early in 2017 which temporarily closed the service to visitors. We were not informed of this by the provider. When we asked the provider why he had not informed us he said he was unaware to forward this type of information.

The provider had failed to make sure the Commission was informed of all notifiable incidents in relation to service users. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and a visiting relative told us they had good relationships with the managers' and staff in the service. One relative said, "I think it's (the service) well managed, there's always staff about and I think mum's content here. Staff are always there when you need someone." A second relative said, "The carers don't wear name badges – I don't know who some of them are." We spoke with the registered manager who said, staff did have name badges, but they were going to be replaced, and these would be ordered shortly.

One member of staff said, "If I have a problem I would speak with the (named registered manager), and if he's not here the deputy or nurse will help."

The provider had a clear understanding of what they wanted to achieve for the people at the service and they were supported by the registered manager, deputy manager, nurses and staff group. There was a clear management structure in the service and staff were aware who they could contact out of hours if needed.

People who used the service and their relatives were enabled to contribute to the quality assurance process and quality of care in the service. One relative said to us, "Yes I've taken part in a survey after a few months – on the whole everybody's good." There was a suggestions box in the foyer of the service, the registered manager stated there had not been any suggestions put forward so far.

Questionnaires were distributed to people's relatives so they had the opportunity to comment about the quality of service offered by the service. We saw some of the feedback had been adopted by the provider, and changes had been made to food and nutrition and personalised activities. Currently there was no collated response from each annual questionnaire circulated to people in the service and their representatives. The registered manager said he would do this following the next questionnaire that was being sent out.

People who lived at the service and their relatives were also invited to meetings with the service's management team. We looked at the minutes of these meetings. We saw that people requested to be able to have more personalised activities such as hand massages which have now been provided. That meant the provider involved people in the quality assurance process which was attempting to provide a culture which was personalised and empowering.

Staff had detailed job descriptions and had regular staff and supervision meetings. These were used to support staff to maintain and improve their performance. Staff confirmed they had access to copies of the provider's policies and procedures. They understood their roles and this information ensured that staff were all provided with the same information. This was used to provide a consistent level of safe care throughout the service.

The deputy manager undertook regular checks in order to ensure health and safety in the service was maintained. We saw records of these checks that had been completed to ensure the building was safe for people.

We saw a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. Staff were aware of the process for reporting faults and repairs, and had access to a list of contact telephone numbers if there was an interruption in the provision of service. Other information included instructions where gas and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

A copy of the last inspection report was displayed in the office of the service, which displayed the rating from the last inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of unsafe care or treatment and transfer of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to make sure quality assurance systems were in place to ensure that records had been thoroughly monitored to protect people from harm and ensure their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour There was a failure by the provider to submit notifications about the care and treatment of people in the home.