Four Seasons Health Care (England) Limited

Carleton House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on the 9 and 10 February 2016.

Carleton House Care Home is a service that provides accommodation and personal care to older people and is registered for up to 27 people. It is not registered to provide nursing care. The care home is a former rectory and accommodation is provided over two floors, accessed via a lift or stairs. On the days of our inspection there were 17 people living in the home.

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

At this inspection we found two breaches of the Health and Social Care Act 2008.You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe in the home. Staff understood and knew how to identify and report harm. Staff understood people's individual care needs and took action to prevent people from coming to harm. Premises and equipment were assessed, reviewed, and maintained. Appropriate actions were taken to deal with accidents and incidents, although these were not always robustly investigated and documented. Safe recruitment practices were being followed. Medication was administered and stored safely.

Staff had the knowledge and skills to meet people's needs, preferences and choices. Staff had training and support from the service that equipped them to carry out their roles. Knowledge about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards was variable. Assessments of mental capacity and best interests were not being made. This meant the home was not following the requirements of the MCA.

People were supported to eat and drink enough. There was sufficient staff to support people who needed assistance to eat. People were assisted to eat and drink independently if possible. Where there were concerns people's weight, fluid and food intake was monitored and reviewed. People were supported to access external health care services when needed.

Staff showed kindness, compassion, and respect towards people living in the home. Staff demonstrated that they knew the people living in the home. People were supported to express their views and make decisions. Relationships with friends and family were supported by the service. People were supported to be independent and their dignity was protected.

The care provided met people's needs and preferences. Staff knew people well including their personal preferences. However, people were not routinely involved in planning and reviewing their care.

An activities co-ordinator was in post. Feedback about activities was mixed. There was no regular activities timetable however there was some planned regular entertainment provided externally.

Staff felt they were listened to and supported by the registered manager. However, they did not feel supported by the provider. Care records did not provide sufficient guidance and were not effective. The service promoted a culture of openness and a desire to learn and improve. Systems were in place for people to raise concerns and provide feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise and report abuse.

There were safe recruitment practices in place.

Medicines were stored and administered safely.

Actions were taken to protect people coming to harm.

Is the service effective?

Requires Improvement

The service was not always consistently effective

The requirements of the Mental Capacity Act 2005 were not consistently followed. Staff knowledge about the Act was variable.

Staff had the knowledge and skills to meet people's needs.

People were supported to eat and drink enough to maintain their health.

People were supported to access healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

People's dignity and independence were promoted.

Relationships with family and friends were supported.

Is the service responsive?

Requires Improvement

The service was not always consistently responsive.

People were not involved in planning and reviewing their care.

Staff knew people's individual wishes and preferences which were met. However they were not always documented fully in people's care records.

There was an activities co-ordinator in post but feedback about activities was mixed.

People were given the opportunity to complain.

Is the service well-led?

Requires Improvement

The service was not always consistently well-led.

Records were not always accurate.

Staff did not feel supported by the provider.

Actions were not always taken to put improvements in place.

There was a culture of openness and a desire to learn and improve.

Carleton House 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 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 inspection took place on the 9 and 10 of February 2016 and was unannounced. Our visits were carried out by two inspectors.

Before we carried out our inspection we looked at the information we hold about the service. This included notifications received by us. Notifications are changes, events, or incidents that providers must legally inform us about. We reviewed this information and information requested from the local authority safeguarding team and quality assurance teams. We did not request a Provider Information Return (PIR) form. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During our inspection we spoke with eight people living in the home, two visitors, a visiting district nurse, and nine members of staff. This included the deputy manager, two senior care staff, two kitchen staff, and four care staff. The registered manager was not at the home on the days of our inspection. We spoke to them by telephone following our visit.

Not everyone living at Carleton House Care Home was able to speak with us and tell us about their experiences of living at the service. We observed how care and support was provided to people and how people were supported to eat their lunch meal.

We looked at three peoples' care records, medication records, two staff recruitment files and staff training records. We looked at other documentation such as quality monitoring, accidents and incidents and maintenance records. We saw compliments and complaints records and records from staff and residents meetings.

Good

Is the service safe?

Our findings

The people who used the service told us they felt safe living in the home. One person said, "I feel very safe living here." Another person told us, "There's a very relaxed atmosphere here. No raised voices. Just as I like it." The relatives we spoke with had no concerns about the safety of their relatives. One relative told us that people were treated well.

The staff we spoke with said they had completed safeguarding training. We saw records that confirmed this. Staff knew how to recognise, prevent, and report abuse. When we spoke with the deputy manager they told us of a recent example they had reported to the safeguarding team. The person's care records confirmed that actions had been taken to safeguard this person. We were satisfied that staff had the knowledge to identify concerns about abuse and report them.

Staff supported people's equality and diversity. One member of staff was able to give us examples of how they supported people with more diverse needs, for example ensuring that a member of staff who spoke the same language as one resident spent time with that person. We also saw care records that took account of people's individual needs regarding their disability. For example, we saw in one person's care records how a certain action indicated frustration and for staff to be patient and ask what is wrong. Staff explained how they would manage behaviour that challenged. We observed staff taking action to resolve an argument between two residents. All staff told us they treated people how they wished to be treated themselves.

The staff we spoke with understood the care needs and risks to the people they supported. A visiting district nurse told us that staff contact them promptly if they have concerns regarding wounds or pressure care for people living in the home. We observed there were informal methods to share information on risks to people. For example, staff shared concerns at a handover meeting about the low fluid intake for one person. We saw records that demonstrated that an awareness of risks to people such as weight, pressure areas, falls, and the use of bed rails were in place. We saw that these records were reviewed on a regular basis.

We saw records that demonstrated that the premises and equipment at the service were risk assessed and managed. For example, routine maintenance for electrical equipment and moving and handling equipment had been completed. There was a completed fire risk assessment in place and staff had taken part in fire drills. Not all staff we spoke with were clear if an emergency evacuation plan was in place in the home. The registered manager told us not everyone living upstairs would be able to independently evacuate the building in the event of an emergency. People did not have personal evacuation emergency plans however we saw people had bedroom fire risk assessments which included if the person needed assistance. We saw minutes from health and safety meetings that showed the fire service had said equipment needed to be put in place to evacuate people from the upstairs of the building. The registered manager told us the provider had consulted with the fire service regarding what action should be taken whilst they waited for the equipment required. The minutes showed that equipment had been recommended in August 2015. At the time of our visit the equipment was not in place. This meant we were not confident that people on the first floor in the home could be safely evacuated.

Accidents and incidents were reported and recorded. The staff we spoke with were able to tell us what incidents and accidents should be reported. They could tell us what actions they would take to respond to and prevent incidents. We saw that accident and incident forms were completed and these were viewed and assessed by the registered manager or deputy manager. The records we saw showed appropriate action had been taken to respond to incidents. For example, we saw one person had fallen several times in the last month. Actions to deal with the incidents had been logged, such as checking for injuries and contacting their G.P. We saw that the person already had a risk assessment in place and had the equipment to alert staff to a fall.

Two people we spoke with said sometimes there were not enough staff and people had to wait for their care needs to be met. One person told us, "About 10-15 mins is the most time" they have had to wait. Another person told us, "Staff do their best" but said recent staff absence had impacted on them having to wait longer than usual for assistance. A relative we spoke with said the home sometimes seemed short of staff but they did not feel that this had a negative impact on people's care needs. Staff told us that there were enough staff most of the time and that staff absence was usually covered. They told us that agency staff were not used and the home had its own bank staff.

Staff files showed us that safe recruitment practices were being followed. This included the health and character checks such as two references, Disclosure and Barring Service (DBS) checks, and health questionnaires to ensure the person was suitable to work in the home. The registered manager told us bank staff who had not worked at the service for a period of time received up to date training and spent two days shadowing before they began work.

The deputy manager told us a staff dependency tool was used as a guide to calculate staffing needs. We saw people were assessed as having high, medium or low needs. Staffing levels were calculated depending on the number of people using the service and the number of people with high, medium, or low needs. The deputy manager told us that if people's needs changed or the number of residents changes the dependency tool was updated so staffing levels could be recalculated and revised if necessary. We checked the staff rota for the last two weeks against the dependency tool and saw that the numbers matched and any staff absence had been covered. On the days we visited we found that there were sufficient staff to meet people's care needs.

People received their medicines safely. One person told us, "Yes they help me with my tablets and they are always available for the staff to bring to me." Staff we spoke with told us the manager carried out checks on their medication administration. We spoke to two members of staff who administered medication they were knowledgeable in how they safely administrated and stored medication. Both were able to tell us what actions they would take if a medicines error occurred. We observed one person being given their medication. They were told what the medicines were and asked if they were ready to take them. We viewed three medication administration records. There were no omissions and stock counts were accurate. We saw that medications were audited on a daily basis to ensure that they had been given accurately and were being stored at the correct temperature. There was a protocol for staff around administering 'as required' medication. The staff we spoke with knew how to administer 'as required' medication safely.

Requires Improvement

Is the service effective?

Our findings

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 in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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 was being met.

When we spoke with staff regarding the MCA and DOLS their knowledge was variable. Several staff we spoke with said they did not feel confident applying the Act in practice. Some staff we spoke with could give examples of the MCA in practice but this was not consistent with all staff we spoke with. One staff member told us, "I have not heard of best interest" and another person was not sure if a mental capacity assessment was needed if the person already had a diagnosis of dementia.

We saw in people's care plans that no mental capacity assessments or best interests decisions were documented when required. For example, one person's care plan said that the person lacked capacity to administer their own medication, however there was no mental capacity assessment or best interests decision recorded. We saw another person's care plan that stated their diagnosis and said 'this means that capacity will be lacking in most areas.' The person did not have capacity assessments in place.

Staff we spoke with knew how to ensure that people did not have their freedom restricted and told us they would report this to a senior or manager if they felt this was happening. DOLS applications had been made, however the three we looked at did not contain mental capacity assessments or best interests assessments. We concluded that the requirements of the MCA and DoLS were not being fully met.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the service did take into account issues regarding consent. One person told us that staff knew who they did and didn't want information shared with and this was observed. A member of staff told us if the person they were supporting did not want their support they would leave them and come back later. We saw that staff asked for people's consent and encouraged them to make choices. We found care files showed consent was sought from people for the use of flu vaccination, bed rails, and photographs.

People living in the home received care from staff who had the knowledge and skills to meet their needs, preferences, and choices. One person told us, "This is a good home where you get all the care and attention

you need." Another person said, "The staff know how to look after me." A relative told us, "The staff really look after my relative and give them every care and attention. I could not ask for better."

The home had a staff trainer in place and the staff we spoke with told us they had completed training that equipped them to carry out their role. One staff member told us that the registered manager made sure that they all completed all the necessary training. We saw that training records were kept up to date and training that staff required was identified and actioned. We saw that staff had completed additional training such as dementia awareness to support them in meeting specific needs of individuals using the service.

The staff we spoke with said they had completed an induction and had spent time shadowing other staff before working on their own. The registered manager told us there were checks in place to ensure new staff had reached the set standard. We saw records that confirmed that induction training was in place. Not all staff we spoke with said they had their competency checked, however senior staff told us that the registered manager checked them giving out medication. A another senior staff member told us that the registered manager checked their practice every six months. We saw records that showed the registered manager visited the home at irregular hours to monitor the service and care provided. We concluded that the registered manger took actions to monitor and check the work staff carried out.

Staff told us they felt supported by the registered manager. One member of staff told us the registered manager, "Has an open door policy" and another told us the registered manager, "Is always there." One member of staff told us how the registered manager had supported them to develop their confidence and experience so that they could gradually take on more complex tasks. The staff we spoke with said that they received regular supervisions and appraisals which was confirmed by records we reviewed.

People were supported to eat and drink enough to maintain their health. On one day we visited we observed lunch being served. People were encouraged to eat independently, with meals being cut up for people when required. We saw that there were sufficient staff to support people who needed assistance with their meal. People were provided with drinks during the meal and throughout the day. Kitchen staff told us about people's individual dietary requirements and we saw that these were recorded in the kitchen. Kitchen staff told us that they offered vegetables, salads and fruit daily. We looked at care records that showed people's weight, fluid and food intake was being monitored and reviewed. We observed in a staff handover meeting that staff shared concerns regarding one person's low fluid intake and agreed to encourage the person to drink more for the rest of the day.

Feedback from people regarding the quality of food was mixed. One person told us, "The food is good and we do have a choice." Another person told us that, "At times the standard of the meals cooked is poor." A relative told us they were concerned about the quality of the food and that their relative did not like the meals. One person told us they had raised some concerns at a residents meeting and that "Some improvements have been made." The registered manager told us they were aware of some concerns regarding the food and had sourced different meat. Records from resident's meetings showed that comments about food had been made and some actions had been taken to improve the food. The registered manager told us as part of their action plan around meal times they ask for people's opinions about their main meal and make a note of any issues.

People were supported to maintain good health and receive support from healthcare services. One person told us, "The staff notice if I am sad or unwell and ask me what is wrong. They try to put it right or ask the doctor to visit me." We spoke with a visiting district nurse who told us that staff followed their instructions and contacted them when they had concerns about people. One member of staff told us they had a good local GP who comes in when called. We reviewed care records which showed us that people were able to

access health care services they needed, for example we saw people had access to opticians, were referred to district nursing services, and continence clinics if required.

Good

Is the service caring?

Our findings

People were treated with kindness, dignity and respect. One person told us, "The staff are so kind and we often have a joke and a laugh." Another said, "Staff are so wonderful and could not be nicer. They treat us so well, are so cheerful and friendly. They will do anything for you. You only have to ask." One relative told us that staff treated people well and another told us the home was, "An excellent home with lovely staff who treat people kindly and with respect."

One staff member told us, "This is a lovely home that puts the people who live here first." We observed staff acting in a kind and compassionate way. When people were upset we saw staff responding to them and offering comfort. We saw one person telling a member of staff they were cold. The member of staff responded straight away by getting them a blanket from their room. We heard staff laughing and joking with people. One person said to a member of staff, "You're in a field." The staff member responded kindly to what the person could see saying, "I'm like a scarecrow aren't I." Staff we spoke with showed they knew and understood the people living in the home. Two members of staff told us how they knew and sang one person's favourite song with them. We heard one member of staff initiating a conversation with a person about a job they used to have. Staff told us that the activities co-ordinator was spending time with people individually to write their life histories. We saw an example of this in one person's care records.

People were supported to express their views and make decisions about their care and support. One person told us, "Yes the staff know how to look after me. They know the way I like things done and if they do not, I soon tell them. Yes they listen to me and are very happy to do as I ask." Another said, "The staff help me to be as independent as I can be." We looked at minutes of residents meetings that showed people were able to discuss their care and were listened to. We saw staff explaining to people what support they were going to provide and respecting their wishes if they declined. Staff told us that the people living in the home had support from friends and family. They said they would involve friends and family to support the person to make decisions. One staff member said, "Where we can we encourage families to be involved in the life of their relative." Staff told us they knew how to access advocacy services if needed.

The privacy and dignity of people living in the home was respected. One person told us, "Yes, staff cover me up when they help me to wash or shower. They close the door and draw my bedroom curtains." We saw staff knocking on bedroom doors before entering. We observed that staff were polite and treated people with respect. We saw that staff promoted people's independence. For example, we saw adapted cups were provided to people so they could drink independently. We observed two members of staff supporting and encouraging a person to walk as much as they could to help maintain their mobility and independence. Friends and family could visit when they liked. One person said, "My family are made very welcome when they visit and staff offer them a drink." A relative told us, "I visit two to three times a week and the staff always make me feel very welcome."

Requires Improvement

Is the service responsive?

Our findings

We saw that people's needs were reviewed regularly, however people were not always involved in planning and reviewing their care needs. One person told us, "They (staff) do ask me sometimes if I am happy with everything." A relative told us, "No, I have not taken part in a review of my relative's care or been asked my opinion by staff." Some staff we spoke with told us people were asked for their opinions. One member of staff said, "The seniors ask the person for their opinions and involve the relatives if they can." We spoke with the deputy manager and a senior member of staff. They told us they do monthly reviews of people's needs. They said if the person's needs haven't changed they record no changes. They acknowledged that this didn't involve asking the person if they thought their needs had changed. This meant that people were not fully involved or consulted in reviews of their care.

The care provided was responsive and met people's individual needs and preferences. One person told us, "The staff are extremely helpful. I asked to have my evening meal at about 7pm instead of 5pm because I like my last meal of the day later. They were happy to do this and they bring me my tea when I ring the call bell." Another person said, "I can do exactly as I choose to do and can get up and go to bed when I wish." The staff we spoke with knew people's choices, wishes, and preferences. Staff told us they treated people as individuals and encouraged them to do the things they liked to do. One member of staff told us, "This is their home so what they want to do is up to them." We saw staff responding to people's needs in a timely manner.

The care records we looked at contained information about people's needs. We saw that some care records documented personal preferences about how their care should be provided but this was not always consistent or detailed. We saw documents which had space to detail people's choices, preferences around how they liked to be supported, important relationships, and things the person liked to talk about. These were blank and did not contain any information. The registered manager told us that they are working on making changes to the care plans. The activities co-ordinator was working on completing life histories with people. These contained personal details such as their favourite drink, flower, what makes them unhappy or worried, and important life events.

The home had an activities co-ordinator in place. The deputy manager told us they were relatively new in post and there had previously been a gap of six weeks with no activities co-ordinator. People told us they did activities such as bingo, arts and crafts, or word searches. They told us musical entertainment is arranged regularly. One person said, "Yes we do have some things arranged for us to do. The singers are good. I like it when they visit us." Another said, "The activities are alright. A bit the same most of the time. You do not have to join in if you don't want. I like to stay in my bedroom and read or watch TV. Yes the staff visit me and have a chat." A relative told us, "They have regular entertainment which is good about each fortnight." We did not see a timetable of activities. Staff told us that activities were not really planned and people were asked what they wanted to do each day. Staff told us that there were no planned trips out of the home but some people were taken out by relatives. The deputy manager told us planned trips out had been discussed at a resident's meeting and they were exploring if they could book a coach to take a trip to the seaside. On one of the days we visited we saw four people colouring in a picture.

People told us that concerns and complaints were listen to and resolved as they occurred. One person told us, "I have no complaints and would tell [the deputy manager] and the staff." A relative told us, "The manager or deputy are mostly available when I visit and they listen to me and sort out problems." The service had systems in place to encourage feedback about the home. We saw records that showed that there were residents meetings and a yearly survey was sent out to people using the service and their relatives. There were no recent complaints, but we saw that historical complaints had been responded to and acted on appropriately.

Requires Improvement

Is the service well-led?

Our findings

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. Although the service had reported some incidents during our inspection we became aware that one incident had not been reported. We found that one person had made allegations of abuse in January 2016. Although the service had acted appropriately in dealing with this and notifying the local safeguarding team, they had not submitted a notification regarding the allegation of abuse to us.

The care records we looked at contained details about people's care needs but these were not always detailed enough, were conflicting and were sometimes incorrect. One member of staff told us that the information is there but there, "Is less flow to them." Another said, "Care plans are okay. They do contain information but sometimes it is hard to find. They are being changed at the moment to make them easier to read. Yes they have the information we need but we prefer the up to date information we get at handover." When we looked at people's care records, we saw one person had a care plan to reduce admissions to hospital which showed they had diabetes, however their nutritional needs care plan did not record anything about diabetes. We saw that the kitchen had separate records which did record people's dietary needs.

We saw that one person had a care plan for bedrails that said the person should be checked every half hour for their safety whilst in bed. Records for this care plan showed they were being checked every hour. We asked a member of staff about this. They told us they were doing hourly checks and the care plan was not correct. We talked to staff who told us what actions were in place to support someone with behaviour that is challenging to others. They told us that food and fluid intake should be logged and the person required hourly checks. Although this was being done the care plan did not specifically state that these actions should be taken. This meant the care records did not have the correct guidance for staff and there was a risk that people's needs would not be met.

Although incidents were responded to appropriately records relating to them were not fully completed. The records we saw showed appropriate action had been taken to respond to the incident however the investigation section of the report was left blank. This meant that we could not see what actions had been taken to investigate the incident and what measures were put in place to prevent the incident from happening again. For example we looked at a medication error record, the deputy manager told us that the member of staff involved had to redo their medication competency however this was not documented in the incident record. We concluded whilst incidents were responded to the incident records did not fully document the actions taken in response.

We saw that quality audits were in place, the audits had identified some of the issues we had identified but not all of them. We saw that an audit on care documents had said there was evidence of people and their relatives' involvement. However the records we looked at did not show this. We saw that one audit had identified that documents which should detail people's choices were not completed. Where issues had been identified there was no action plan in place. This meant we were not clear if any actions were being taken to make improvements when identified. The registered manager told us that that the provider used to send a

regional manager to undertake monthly audits but this hadn't happened since April 2015. The registered manager told us they were completing these audits themselves and sending them to the provider. They told us they hadn't received action plans for the audits back and had not completed any themselves. Staff told us that the provider had undertaken a restructure about eighteen months ago. The registered manager, deputy manager and senior staff told us that this had impacted negatively on the support given by the provider. Staff told us communication from the provider about changes could be better. One person said, "Staff get the idea but feel in limbo about it (the changes) happening." They told us that the provider wanted them to use new care plans as part of their restructure but they hadn't been given the new forms. They told us they had training on writing care plans, however they said they were told they would have feedback from the provider to check there were doing this correctly and this hasn't happened. We saw that training from the provider about the Mental Capacity Act said capacity assessments should be included in people's care plans. The deputy manager and senior advised the provider had not sent mental capacity forms.

The fire service had highlighted the need for emergency equipment to evacuate people from upstairs six months ago, but this equipment was not in place. The manager had requested equipment at the time and was told by the provider that this was subject to further discussions in September 2015. Minutes from a December Health and Safety meeting recorded this as needing to be followed up. We were concerned regarding the length of time that had passed and that equipment was still not in place at the time of our inspection. We shared our concerns with the registered manager, they chased this up with the provider. The registered manager told us that they had placed an order for the equipment required themselves. We were concerned that there was a lack of action to put improvements in place both from the provider and the home.

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

There was a registered manager in post. Staff told us morale was good and spoke positively of the registered manager. Mechanisms for feedback were in place. The staff we spoke with told us staff meetings gave them opportunities to talk about the service and changes were communicated. Staff told us they felt listened to and supported. One staff member said, "The manager encourages us to let them know our views." Another member of staff gave us an example of a time when they had suggested a solution to a problem. They said the manager acted on their suggestions and this helped solve the problem. Staff spoke of an, "Open door policy" and told us they could speak freely. We saw that the provider sent out a yearly questionnaire to people using the service and their relatives. The results had been analysed and the manager told us an action plan would be written. All the people we spoke with thought the service was good, one said, "I would definitely recommend this home as a good place to live and be cared for by excellent staff." There was a culture of openness as well as a desire to learn and improve. One staff member told us the service had an emphasis on learning from mistakes. Another told us, "The manager is good and is very approachable. They sort things out quickly and are not afraid to tell us how a thing has to be done." When talking with staff we found they showed a commitment to listening to and addressing concerns.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: The provider did not act in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Care records did not contain an accurate, complete and contemporaneous record. Actions were not always taken to monitor and improve the quality and safety of services or to monitor and mitigate risks relating to health and safety Regulation 17 (1) (2) (a) (b) (c)