Porthaven Care Homes Limited

Haddon Hall Care Home

Inspection report

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Date of inspection visit:
25 June 2018

Date of publication:
06 August 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 25 June 2018 and was unannounced. At the last inspection we rated the home overall as 'Good' with a request to the provider to make improvements within the 'Responsive' section. At this inspection we found some improvements had been made, however further improvements were required in the 'safe' and 'well-led' sections of the report.

Haddon Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home has accommodation set over three floors. Each floor has access to dining areas and small and large lounge or relaxation spaces. Each room has an ensuite; there are also large communal bathrooms with adapted baths on each floor. There is a small gym and a dining area which can be used by people and their relatives. The garden is access with areas of seating and a circular pathway to support people to navigate around the landscaped flowerbeds. The upper floors also had access to the outside on large balconies with seating.

The service was registered to provide accommodation for up to 75 people. At the time of our inspection 60 people were using the service.

Haddon Hall has 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.

There was not always enough staff to support people's needs. Medicine was not always managed safety to meet peoples prescribed needs. Risk assessments had not always been completed and behaviour plans were not completed to support a consistent approach. When audits had been completed they did not reflected actions which required completion. New systems had not been checked to ensure staff had the knowledge to use them effectively.

People enjoyed living at the home. It was well maintained and any risk to infection was managed. Staff showed knowledge about people's needs and they had established relationships with people. Dignity and respect for people was maintained.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Their views were considered and improvements developed from these meetings and connections.

Staff understood how to protect people from harm and when required people were supported with their health care needs. Nutritional needs had been considered and dietary needs met.

Activities and areas of interest were on offer, which linked traditional things with new initiatives. The community had also been encouraged to link with the home and partnerships had been developed.

Complaints had been responded to and the registered manager understood their role in relation to notifications. We saw the rating was displayed at the home and on the provider's website.

We found breaches 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.

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.

There was not always sufficient staff to support people's needs. Some risks had not been identified and guidance provided. Medicines were not always managed safely.

People had received training on how to protect people from harm and lessons had been learnt through a range of events. The home protected people from the risk of infection.

Is the service effective?

Good

The service was effective

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff received training for their roles. People's wellbeing was considered and referrals made to health care professionals. Meals met people's dietary needs and choices were offered.

Is the service caring?

Good

The service was caring

People had established relationships with staff and felt they were kind and caring.

People's dignity was considered and staff respected them. Relatives were able to visit anytime.

Is the service responsive?

Good

The service was responsive

People were able to embrace activities and things of interest. Care plans reflected people's basic needs. Consideration was

made in relation to accessible information and spiritual needs.

Complaints had been addressed to provide people with an apology and outcome.

Is the service well-led?

Requires Improvement

The service was not always well led

Audits had not always been used to reflect on required changes and details within the care plans had not been developed.

People enjoyed the atmosphere of the home and had been consulted. Staff felt supported by the registered manager. The registered manager understood their registration with us and completed notifications and displayed their rating as required. Partnerships had been developed to provide care across different areas for people.

Haddon Hall 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.

Our inspection was unannounced and the team consisted of one inspector, a specialist advisor 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. A specialist advisor is a professional who has expertise in a specific area. Our specialist was a nurse.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. We used this information to formulate our inspection plan.

We also 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.

We spoke with eleven people who used the service and two relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with them in communal areas.

We also spoke with four members of care staff, two bank nurses, the cook, and the maintenance person, a member of the domestic staff, the deputy manager, the training manager and the registered manager. The regional manager was present when feedback back about the inspection was provided.

We looked at the care records for ten people to see if they were accurate and up to date. In addition we looked at audits completed by the home in relation to falls, incidents and infection control. We also looked at minutes for meetings and feedback events and recruitment folders for three staff to ensure the quality of

the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

There was not always sufficient staff to support people's needs. One person said, "Staff would stay and chat, but they haven't got the time. Very often they're short staffed, you notice how much longer it takes them to get everything done." A relative told us, " Staff are kind and caring, but things are often down to what they have time to do. It might be better if the same nursing staff stayed on the same floor like the carers tend to do then you'd get the consistency of care." Some people had been allocated one to one staff from the commissioning authority. These hours were to support a person due to their behaviours which could harm themselves and others. We saw that they had not always received the one to one support as commissioned.

During the morning we saw the staff member allocated to support this person was also responsible for people in the communal space. The person asked to go to the garden and was told they had to wait, the longer they waited the more anxious they became. The person was eventually taken to the garden; however the staff member also took another person with them. Later during our visit we saw the person had left the dining area unsupported. The person went to a small lounge and on sitting on the sofa misjudged it and landed on the floor. The person then had to be hoisted from the floor which caused them distress. This meant we could not be sure the person was receiving the support as allocated.

We spoke with people about the responsiveness of the staff when they used their call bells. One person told us, "There is not enough staff. I have to wait a long time when I press the buzzer." Another person told us, "At first it was quite good now it's not so good. This morning staff didn't turn up for ages, usually its two people, but sometimes only one." Our expert by experience visited a person. They told us, they had buzzed for the staff member to assist them with a personal care need. The staff had responded to the buzzer and turned it off saying they would return within five minutes. Our expert was with the person for 15 minutes and the staff did not return during this time. The person told us, "They are a bit short staffed." We checked back with the person 30 minutes later and they confirmed they had received the support they required.

The home has a call bell system. In the PIR the provider told, they could use the data to reflect how people's needs were being met. However at the time of the inspection this analysis had not commenced. We reviewed the data from the call bell system for the previous three days. We saw that on several occasions the call bells had rung for between 10 to 15 minutes, before they were responded to. We noted one call bell, was not registering on the system at one end of the corridor. We reported this to the maintenance person who looked to rectify this error. We discussed the call bell response times with the registered manager who informed to us they would be doing the analysis and using it to consider staffing levels.

We saw that on the ground floor, the provider had a 'waitress' staff member who supported people with their meals. Staff we spoke with on the first and second floor all commented that people would benefit from a similar role on these floors. One staff member said, "People need a lot of prompting and supervision, along with reminding to drink, so this role would be really useful."

This demonstrates a breach in Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home used an electronic system for the medicine administration. On the day of the inspection, the medicine had been booked in the previous day as it was the medicine monthly change over. We saw that the stock and the related records did not always tally. This meant that when the nurse completed their medicine round 15 products were recorded as out of stock, however there was stock in place. This was due to the stock did not always being reflected on the electronic record.

The two morning medicine rounds on the first and second floor were not completed until 12.15 pm. This meant people who require medicine on a four hourly basis could be affected and it would have an impact on the management of their pain relief. In the provider's PIR it was identified the time factor had been observed and commented on at the last inspection. The registered manager had written that they felt confident the new system had improved the time scales and that the length of time was being recorded and had reduced to an acceptable level. We found and people told us that medicine times were not consistent. The nurses on duty during the inspection visit had not received direct training on the system. Some nurses had received the training and they were responsible for cascading this to the other nursing staff. No competency checks had been completed to be assured that the nurses dispensing medicine were able to use the system effectively.

Medicine stock was not always managed safely. One person told us, "I have run out of eye drops. I have Glaucoma and need these eye drops every day." We saw the person had been without their medicine for over a week. We observed during the medicine round; some medicine was prepared by the nurse and then refused by the person. The medicine was for pain relief and the person was prescribed one tablet four times a day; however the nurse had dispensed two tablets. We checked the stock of this medicine and found it to be incorrect. Another person required a three monthly injection. We were alerted to this by the high level of stock and the use by date on this medicine. The nurse told us initially that the medicine had been discontinued, after further investigation it was noted it was still prescribed, however the system had not allowed for the distance timeframe for the next administration. This error was rectified; however it gave us concern as to the overseeing and the checks on the medicine system.

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

People's safety was not always monitored. We saw that some risk assessments had not been completed when some specific equipment was used. For example, two people had specialist chairs which were in use, however risk assessments for these had not been completed. We saw one chair did not have a foot plate, so the person's feet were observed to be dragged along the floor. The other person was seen attempting to climb out of the chair which resulted in three staff supporting the person to ensure their safety. We discussed this with the registered manager who confirmed the chairs had not been risk assessed, but agreed to action this and consult an occupational therapist.

We saw when other equipment was used, staff showed knowledge in using it and placing the person at ease. One person said, "When staff support me they always bring a lift and I feel safe when they lift me in and out of the chair."

Some people expressed themselves in ways which could harm themselves or others. We saw that the care plans did not contain the details for staff. One staff member said, "I would have to look at the plans as I am not sure. We all seem to use different techniques." They added, "To be honest we don't get time to look at the care plans." We reviewed the care plans and found that when things had occurred these had been recorded, however plans to reflect any triggers or distraction techniques had not been completed. This meant we could not be sure the person would receive a consistent approach to their behaviour.

When people had fallen measures had been put in place to reduce the risk of the incident reoccurring. One person told us, "The staff keep an eye on me; they look out for my safety." Another person said, "I've no complaints, I take a long time to do things and they don't rush me. When I had a fall I lost my confidence and the staff have encouraged me to try and walk again." We saw that low beds were used to reduce the risks when people fell from their bed; in addition sensors were used to alert staff when people moved so they could respond quickly.

We saw that people's skin had been protected. One person had arrived at the home with sore skin following staff care the sore had healed. A relative told us, "The staff know what they're doing, they turn [name] and their sores have cleared up." We reviewed records which confirmed that when people required regular movement changes these were completed as agreed in line with their care plan.

People told us they felt safe. One person told us, "I feel safe living here." Another added, "Oh yes, I definitely feel safe here the staff are marvellous." A relative we spoke with agreed with these statements they said, "[Name] is definitely safer here than at home." Staff told us they had regular training in safeguarding adults and they were knowledgeable about indicators of abuse and knew how to respond should they have any concerns. Staff felt confident that any issues they reported would be acted on appropriately. The registered manager had taken action to make referrals to the local authority safeguarding adults team when required and, records showed action had been taken to reduce immediate risks to people.

We saw that lessons had been learnt through safeguards. The registered manager had a regular meeting with the safeguard lead from the local authority to review any outstanding safeguards, and lessons learnt. This included the types of concerns which should be reported and the best approach.

We saw that checks had been carried out to ensure that the staff employed were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. The records we reviewed had all the relevant checks required.

People had been protected from the risk of infection. One person said, "I think the home is well maintained and clean and is like a five star hotel." Staff used protective items like aprons and gloves when they provided personal care or assistance with meals. The home had a five star rating from the food standards agency, which is the highest award given. Cleaning schedules had been completed and the environment maintained.

There was an onsite maintenance person. We saw that all the required checks had been completed, for example, fire and water tests. The maintenance person told us, "Every day is different. You get a rapport with people and feel included in the home." They told us they had access to any materials they required for repairs and other contractors were available for larger projects or repairs. We saw each person had an individual evacuation plan and these were available in the fire evacuation information box located in the reception. This is to support if an evacuation was required, for example in the event of a fire. At a recent meeting a relative had enquired about the evacuation procedure and this was explained and documented on the relatives meeting notes posted on the website of the home.

Good

Is the service effective?

Our findings

Staff had received support and guidance in connection with people's specific long term conditions. We saw when a person required specialist equipment for their medicine staff received training and information from the correct health care professional. Other support networks had also been made to ensure the current guidance or legislation was being followed. For example, nurses had spent time with staff at the local hospital to observe updated approaches to end of life care.

Staff had received training in a range of areas to support their roles. The home had a fulltime in house trainer. This role ensured that staff training was up to date and any focus on specific training needs was followed up. The trainer told us how they had introduced some specific training in relation to dementia. This involved a 'dementia suit' which places the staff member in a virtual environment to experience how it feels to be living with dementia. In the PIR the registered manager told us how they had offered this training to staff and relatives. The feedback from the training was that it raised awareness and had a positive impact on how staff responded to people.

When staff commenced their role, they received four days of training, following by introductions with each head of department before commencing shadowing with experienced staff. Once their probation period was completed staff then complete the care certificate or another nationally recognised qualification in care.

We observed the midday meal. Staff approached each person, explaining what was on the menu and asking them to choose. This encouraged good interactions as people had to choose each course. These were followed up with the offer of a warm drink. Juices were also offered and served in glasses and ice was on offer. One person told us, "I think the food is good and they give me small plates, which I like." All the people and relative we spoke with said the food was of a good standard. Tables were laid out with serviettes and condiments. Some people also had individual sauce boats so they could be independent.

We spoke with the cook. They told us how they planned the menu taking into account people's dietary needs and personal choices. When people lacked an appetite or lost weight, health care professionals were referred to. One person told us, "I'm not interested in food, and I have lost weight. The staff weigh me regularly." When assessments had been completed any advice and guidance was shared with staff and the kitchen. For example, soft diets or allergies or long term health conditions.

People told us staff were responsive when they required health care professionals. One person told us, "When I was unwell the nurse rang the doctor immediately. It turned out I have a hiatus hernia. This means I can only eat certain foods and the home are able to cope with that quite well." A relative told us, "Staff call all the health professionals quickly if needed."

We saw that the home had recently aligned with one GP practice and the majority of people have agreed to register with this practice. The PIR reflected on the positive relationship which had been developed with the GP who provided a fortnightly ward round. This support had also included some medicine reviews. One person told us how their medicine had been reduced. They said, "Staff are checking my blood pressure daily

and checking on me since the changes to make sure I am okay." A relative commented, "[Name] is in better health now than when they came in here."

To support people's health the clinical staff meet on a monthly basis. This was to reflect people's health needs. For example, at a meeting in April it was identified one person was at high risk of falls and they were also expressing behaviours which were challenging to manage. Following a referral for additional support they now received one to one support and their falls had reduced.

People and relatives enjoyed the environment of the home. One person said, "The garden is lovely and well kept." We saw the home was well maintained. People were able to personalise their space. There was also the opportunity to use different spaces for families and relatives. For example, the private dining room which families could use for celebrations and gettogether. There were several small lounges which could be used for people to have private time or meetings. The secure garden was accessible from the downstairs lounge. In addition people could access some outside space on the first and second floor onto balconies with patio furniture.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and 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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

We saw when people lacked capacity an assessment had been completed and any decision was supported through a best interest process. For example, when people required medicine covertly. This is when people are unaware they are receiving their medicine, usually disguised in food or drink. The best interest meeting had included professionals and people who were important to the person. When people's restrictions under a DoLS had been authorised we reviewed the conditions and were able to confirm these were being met.

We observed the staff asking for people's consent before they supported them. On occasions they also provided an explanation to the reasons why the support they offered was needed. For example, with personal care. One relative said, "The staff ask for consent before they do anything." This showed us that people were supported to make choices and their decision respected in line with the MCA requirements. .

Good

Is the service caring?

Our findings

People felt comfortable with the staff. One person said, "Staff are lovely, they're excellent, they're like friends." Another person said, "You can talk to the staff they're friendly. Yes I think they get to know you. It was my birthday last week I had a cake with candles and cards." Staff we observed showed they knew people and we saw positive interactions. These included holding people's hands and offering affection.

One person was observed to be upset. A staff member placed their arm on the person's and spoke with them for a few moments. The person appeared comforted by this. We overheard staff and a person comparing notes from a recently watched television programme. Both seemed animated and interested in each other's views. One person told us, "I needed 24 hour care as I couldn't live alone. I've got no grumbles about how I'm looked after the care is amazing."

People were able to choose the support they required in relation to their personal hygiene. One person told us, "I prefer a bath to a shower and the staff help. I can have a bath whenever I like and I feel safe when staff used the bath chair." Another person said, "I have a shower every three days, but I can have more if I wanted." Staff knew people well and were able to support them with understanding any changes. For example, we heard a staff member supporting a person to understand their feelings and urges after they had stopped smoking. The staff told us, "They have given up smoking by used the patches, but occasionally they get an urge which is probably not uncommon or forget they had given up. Once we have explained things they are usually okay."

People's privacy was respected. One person told us, "Staff are very nice they don't boss you. I feel respected, staff always knock on my door and treat me nicely. I would recommend it here, you're allowed to be yourself." We saw one person returning from the bathroom. They were suitably covered up and we observed they enjoyed chatting and laughter with the staff member. Another person walked into the lounge in their nightwear, staff quickly responded to collect a dressing gown and slippers to maintain their dignity.

Relative told us they could visit anytime. In the reception of the home refreshments were available and relatives had also been encouraged to join in meetings and events at the home.
The manager was aware of lay advocacy support, however no one was currently accessing this support. Lay advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes.

Good

Is the service responsive?

Our findings

At our last inspection whilst the provider was not in breach of any regulations, we had reported that people and their relatives felt that care was often but not always personalised. We saw at this inspection this area had improved.

When people showed an interest in moving to the home the registered manager had completed an assessment. This ensured they were able to meet the person needs. One staff member had expressed as part of their development to be part of the assessments process and this was being supported. Care plans had been developed on the new electronic system. The system covered 25 elements of peoples care needs via an initial drop down box. We saw this aspect of the care plans had been completed.

People were supported with access to information. The Accessible Information Standards (AIS) is a framework put in place from August 2016. This is a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given. One person told us, "They keep you informed here. I have two newsletters. This one has photos and articles of what happened 50 years ago at this time, the other one a timetable for the week called "Leisure and Wellness programme." We discussed this area with the registered manager who told us they were looking into other ways they could make information accessible, for example larger print or easy read versions.

Assessment of people's diverse needs were in relation to the protected characteristics under the Equality Act 2010. People's diversity and sexuality was considered and identified people's personal preferences and how they wanted to be supported. We saw examples from people's care records that showed people's diverse needs such as religion or cultural needs and preferences were known. One person told us, "I receive communion regularly." We saw that the local church visited on a fortnightly basis and some people had their own spiritual support provided privately.

People were supported with their interests or daily stimulation. One person told us, "There are lots of things to do, but I don't always do them." They added, "I have made a friend, who told me there was scrabble club happening on Friday, which I might go to." Some people had been encouraged to support daily activities; one person delivered the daily paper to people. Other people were happy with their own company. One person said, "I don't join in any activities, I'm friendly but I don't socialise and they don't press me."

The home had embraced new technology to support peoples recreational and health needs. We saw that desk cycles had been used to promote activity for those who are unable to use a full size bike. These can be used whilst sitting in a chair. Other people were benefiting from the use of a virtual assistant called 'Alexa'. This is an electronic device which linked to the internet to access music and news from a voice request and plays them at a volume and speed to suit the person. The newsletter also reflected the use of virtual reality experience which was being developed. This is an electronic eye mask which takes the person through a visual experience.

Community links had been established. Nursery children visit the home weekly to sing and interact with people. A local music and memory group had used the home as a venue to meet; they welcomed people from the local community. The home had entered the local Buxton in Bloom competition. Another community group had been involved in making some 'Totem Poles' for the garden, which we saw had featured in the local paper and were now displayed in the garden. The home had also linked in with the 'Buxton Garden Trail' offering refreshments to people.

There was a complaints policy at the home which was displayed in the reception area. We saw complaints had been responded to in line with the provider's policy. This included an initial acceptance letter, a full investigation and then a letter to apologise and reflect on any outcomes. Informal complaints had also been responded to reduce the risk of them escalating and to consider any trends. We saw how a complaint in relation to the soft meals had commented the puree meal contained some lumps. This had been responded to and action taken. For example, the provider had purchased a new piece of equipment which pureed the food to a smoother consistency and staff had also received additional training. This shows the provider listened to and addressed complaints or concerns.

At the time of our inspection, the home was not supporting anyone who was coming toward the end of their life. However, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their support plans. A recent thank you card read, 'Loving care given to [name]. You played a large part in the last weeks of their life.' Nursing staff had also linked up with the local hospital to obtain skills and establish links so that they were equipped when this area of care was required.

Requires Improvement

Is the service well-led?

Our findings

We saw that the provider had introduced an electronic care system. The PIR reflected the system saying that it had a lot of drop down boxes and the challenge was adding the content to make the care plans person centred. We saw that this aspect of the system had not yet been completed. The deputy told us that when information is added to one section, this was reflected in the other areas. However we did not see this in practice. In some of the care plans we reviewed we saw the information was not always correct. For example, in relation to the information about a person's thickener and the equipment needs. Staff we spoke with were aware of the people's needs and we saw that these had been met. However the system had not been audited to reflect its progress in containing all the relevant information. Staff had received some training on the system; however staff were still struggling to find information or being able to identify possible risks.

We saw a person was expressing discomfort. When raised by a relative this could be related to their bowel needs. We checked the records and found that no action had been taken for over three days, to provide some medicine support for this person. Staff had completed the daily records and information, however the action triggers which should have highlighted this area were not clear to staff. We discussed this with the registered manager and they told us the plan was to rectify this with the 'Resident of the day' approach. This gives a focus on one person on each floor to review and updated the care plan. However we saw that plans recently updated still showed drop down responses and updates had not always been made. Audits or sensor checks had not been completed on the system to check that the information or understanding of the system was working correctly.

The electronic system for care plans was accessible from screens on the corridors. Staff told us they were impractical as they are not at an easy to use height and standing for long periods in the corridor is not ideal. In addition we identified this could be a data protection issue as information could be overseen by others passing by. We did not observe any staff using these. The registered manager told us, "Data protection risks are mitigated with a time out of 60 seconds and staff are advised in training that if there is activity in the corridor that they move to the nurse's station." They also told us they were looking into hand held devices which would be more practical.

We saw that audits had not always been completed consistently. We reviewed the medicine audits which showed some questions could be interpreted differently to give a yes or no answer. On the three months we reviewed, they had been responded to differently. In addition we saw when actions had been raised they had not been completed or signed off. The registered manager told us that new audits were being developed to link in with the new medicine system.

People enjoyed the atmosphere and had been consulted about their thoughts on the home. One person told us, "I would recommend it here, because I think everybody is kind, the food's okay, it's cleaned every day, and the garden's lovely." We saw that meetings had been held and any comments or requests had been actioned. For example, new coloured plates for the dementia unit had been requested. These had been

ordered and the home was anticipating delivery. A person had requested a key to their room so they could directly access the garden. This request had been arranged. Notes from these meetings and any surveys were displayed on the provider's website. The registered manager told us they planned to review how they could obtain peoples thoughts who were unable to attend the meetings.

Staff felt supported. One staff member said, "I have regular supervision. We cover training , they are hot on the training here and you get a test at the end." Other staff told us they received support with their role and they felt confident in going to the management for any needs.

Partnerships had been developed with a range of health care professionals. For example, the community rehabilitation team and the local mental health team. They provided guidance with people who expressed behaviours which placed themselves or others at risk of harm.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We saw the rating was displayed at the home and on the provider's website.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured there was sufficient medicines to meet people's prescribed needs. The system used to support the administration had not been evaluated and staff did not all feel confident using the system due to lack of training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient levels of staff to respond to people's needs. The provider had not reflected on the response times of call bells to consider the staffing levels in meeting peoples needs.