Castletroy Care Home Limited

Castletroy Residential Home

Inspection report

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Bedfordshire
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Tel: 01582417995

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Castletroy is a residential care home that was providing personal care to 51 people aged 65 and over at the time of the inspection.

People's experience of using this service:
People we were able to speak with spoke highly of the staff who supported them. These people said staff were kind, thoughtful, and caring. People told us that staff promoted their privacy and their dignity when they supported them. However, we found that people who were living with advanced dementia and spent all the day and night in their beds in their rooms, were not always supported in a caring way.

We also found some shortfalls. Some safety checks were not being completed about the home, which put some people at potential risk of experiencing harm. Rooms storing equipment, domestic cleaning items, tools and used incontinence items were not secure. A person living with dementia was seen visiting these rooms.

There was also some poor practice in terms of preventing infection control risks which could make people unwell.

These issues relating to people's safety resulted in a breach of the Health and Social Care Act 2008.

People received their medicines as prescribed. However, there were some shortfalls when supporting some people with as required medicines and controlled medicines.

We made a recommendation to improve their systems to ensure medicines were given in a safe way.

People who were living with advanced dementia who did not leave their bedrooms did not always receive good quality care. There was a lack of stimulation and consideration for these people. The management team were not checking if they were providing a dementia friendly service for all those who were living with this condition. This included the management of the premises.

We made a recommendation about improving the dementia care at the home.

Plans to support and promote people's well being who were living with depression were not always complete.

We made a recommendation about improving these plans and to update their practice.

The management team had responded to concerns identified at the last inspection. We received no concerns or found any indicators that people were being got up early. Various improvements had taken place in terms of promoting people's safety at the home.

Despite this we found some shortfalls in how effective the management team were at identifying areas of improvement and taking action in these areas. Audits were not always effective. We had reservations about the culture of the management team.

A person's relative told us, "I do actually take [relative] out to my house, and the words [relative] uses when [relative] is tired is, can you take me home now, that speaks volumes."

People who could talk with us also spoke highly of the entertainment at the home. One person said, "I love the musical entertainment, we are told in advance if a singer or musician is visiting, other than that, there's lots of things to do in here, you would never get bored."

We found that people were being supported in a way which promoted their physical health. Health professionals were contacted when people were unwell. The home had a electronic record system which contained some good data, to show how the service was supporting people and how they were responding to the risks which people faced.

Staff had a good understanding about what abuse could look like and what they must do in these situations. The registered manager was checking staff competencies in their work.

Staff told us how they helped people to make their own decisions. One person said, "Staff go to my wardrobe and bring clothes out to show me, would you like to wear this, or would you like this."

This service has been in Special Measures. Services which are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

More information is in the full report.
Rating at last inspection: Inadequate, the report was published on 30 October 2018.

Why we inspected: This was a planned inspection based on previous rating.

Follow up: Ongoing monitoring and we will review the action plan. We will inspect the service again to check improvements have been made.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement

Castletroy Residential Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by one Inspector, two assistant inspectors, a specialist advisor who was a registered nurse and a specialist in dementia care. Two Experts by Experience were also present at the inspection. An Expert by Experience is a person who has experience of supporting people who may use this type of service. Both Experts by Experience have experience of supporting people living with dementia.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Service and service type:
Castletroy is a care home. People in care homes receive accommodation and 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 service provides accommodation and care to up to 69 people. At the time of the inspection 51 people were living at the home.

Notice of inspection:
We did not give notice. The inspection took place on 10 April 2019.

What we did:
●Before the inspection we looked at the provider information report (PIR). 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 asked the local authorities who have placed people at the service for their views. Positive feedback was given.

●We checked statutory notifications which the provider must send us by law.

●During the inspection we spoke with seven people who lived at the home, some people could not communicate with us in ways which we fully understood, but we completed observations throughout our inspection.

●We also spoke with five people's relatives; seven members of staff; also, the registered manager two deputy managers and a consultant working at the home.

●We looked at six people's care records, three staff recruitment files, and competency records. We also looked at audits, medicines records, and records of various safety checks.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Preventing and controlling infection

● When we inspected on 10 April 2019 improvements had been made from the last inspection. However, we still found some issues which needed improvement.

● We found rooms which should have been secure, but they were not. Rooms storing hoists, and another room storing used incontinence items were not kept locked and were unsupervised. Two other utility rooms contained detergents such as a bottle of bleach and white spirit. A drill was in another room, all these rooms were left open. Spare plastic bags to store waste were left available in some of these rooms and bathrooms. These rooms were not secured. We saw a person on three occasions enter two of these store rooms. This person was living with dementia and presented as confused. One room had a sign to remind staff to secure this room after use, but it was not secure. Doors leading to this area were also not secure. We told a member of the management team about this and the bleach was removed, but the drill remained.

● Other risks were not well managed including hygiene standards, cleanliness of furniture, fire safety procedures and unsafe disposal of contaminated waste. We found a plastic glove covered in faeces in an open infection control bin. This should have been placed in a bag. This room was not secure. We found another infection control bin with brown matter on it. When we spoke with a member of staff about this, they said, "It's just that time of day." This was not seen as an infection risk.

● Arms to chairs were sometimes stained through use. On some chairs the fabric had broken down or become ripped. There were dents in the paint work, a hoist had chips to the paint work of its base. These are all potential infection control risks.

● The back door in the kitchen had a protective fly cover. The door was open, and this cover was broken and was dirty.

● A person had had multiple falls, a referral to a falls specialist team was made. However, action had not been taken to try and prevent this person falling again in the meantime. When we spoke with a member of the management team about this they said, "It's just bruising and grazes." The provider's response had not fully considered people's safety during this time. This put people at potential on-going risk of harm.

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

● We found that various fire safety checks were taking place. However, we noted in a recent fire assessment

from the fire service a recommendation had not been followed up. We were told this was contradictory to the assessment the service had had from another source. However, this had not been questioned and resolved. People had fire risk assessments in place but some of these were not complete and had missing information. The registered manager told us that this would be updated. We identified that some automated door shutting devices did not work correctly, we also suggested this was followed up.

Systems and processes to safeguard people from the risk of abuse.

● Staff now had a completed knowledge and good understanding about how to protect people from potential abuse. Staff knew of the reporting avenues if they had concerns.

● The people we spoke with told us that they felt safe. One person said, "I know I'm safe here, the [staff] are all about, sometimes I wander off (forget my room number) but they bring me back, I can leave my door open wide and I know I am ok, I have never heard or seen anything un-toward."

●Another person said, "I feel very safe in here, more so than at home, I had burglars in my home it frightened me, I also keep falling over, so I feel very safe here, whenever I have rung the bell, [staff] have come straight away."

●A person's relative told us, "I used to come every day. I can trust [staff], [relative] is safe and I come now three times a week, that shows they are doing something well."

●The service was using an electronic records system. People had risk assessments in place which identified the risks which people faced. There was a plan to support staff to manage these risks.

●Staff told us how concerns or changes in people's needs were shared with them. All the staff we spoke with knew what to do if a person hurt themselves.

Using medicines safely

● Medicines Administration Records (MAR) had been accurately completed. We checked some people's medicines and found what remained tallied with the MARs. However, with some medicines we found that on three occasions the record book was not counter signed by another member of staff. This is not safe practice.

● Temperature checks for the storage of some medicines were not always completed. We found some fruit and milk shakes to help people increase their weight, were being left in a warm room and were not being kept in a fridge. This put people at risk of harm.

● People had protocols to guide staff in relation to their as required (PRN) medication. However, there was some missing information in these for example side effects and review dates. There was no clear plan for staff to refer to in relation to how to identify if a person was in pain, who could not express this.

● Some people were taking prescribed medicines to help manage their mental health needs. One deputy manager showed us that they had a good up to date knowledge about certain mood controlling medicines. However, the potential negative and life-threatening side effects for one person taking a certain medicine were not known by a senior member of staff who could administer this medicine. This person's MAR did not explain what these signs could be. We asked the management team to rectify this as soon as possible. We understood that a member of the management team started to address this issue straight away.

We recommend the service seeks advice from a reputable source to ensure that PRN and other medicines are always managed and administered in a safe way and they update their practice accordingly.

●The people we spoke with said staff supported them with their medicines. One person said, "I have my medicine regularly, they [staff] always stay till I have taken it." Another person told us, "I am on medication, it's like clockwork."

Staffing and recruitment

● New staff now had all the required pre-employment checks satisfactorily completed.

Learning lessons when things go wrong

● The management team had produced a positive action plan relating to the previous short comings of the service. Improvements had been made.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● When people had mental health needs such as depression these were identified in their risk assessments. However, there was a lack of detail in these people's care plans to support staff to fully manage these needs. This could have a negative impact with helping people to improve their mental well-being.

We recommend the provider seeks advice from a reputable source about best practice in the management of depression and updates their practice accordingly.

Supporting people to eat and drink enough to maintain a balanced diet
●The people we spoke with spoke highly about the food. One person said, "The food is very good, they never stop feeding us (person laughed) look they have brought me fruit and another cup of tea, it's like that all day, not just because you're here." Another person said, "The food is very nice, like what I would eat at home, I enjoy my meal times."

● We saw people having snacks and drinks in between meals including fruit and savoury snacks. However, we saw that staff often did not offer people a choice of drinks. In addition, where some people were cared for in bed, their drinks were not always accessible.

● In one person's care plan who was at risk of choking, it stated the person was to have their food pureed and small cut up food. The guidance in the person's care plan was unclear in which situations this was applicable and was contrary to the guidance given from a speech and language therapist (SALT). We asked the registered manager to clarify the advice to ensure the person's needs were safely managed.

● At times we saw that staff did not always promote choice with people who were living with dementia. On one occasion, a member of staff asked a person who was fast asleep in a communal part of the home what they wanted for lunch. This person did not answer, the member of staff said in a frustrated tone, "I will make a decision for you then." This member of staff did not always work at the home and could not be sure the choice they made was right. They should have consulted with another member of staff who knew the person.

● When people were being seated for lunch some staff checked again that people were happy with the earlier meal choice. This is good practice for people who are living with dementia. However, staff did not ask everyone who had memory problems. For those people who could not make a choice easily, appropriate techniques were not used to offer people a choice such as, a plated-up meals or pictures. Staff did not

always support people who had difficulty locating their drinks and eating their food.

● We were told how the chef made pureed food look appetising by using moulds or by piping the food, so it looked like the food they were eating. .

●One member of staff supporting a person who needed a pureed diet did tell the person what was on the spoon. Another person was supported to eat their food. We saw this was at their pace, and they checked if the person was enjoying the food. One member of staff said to a person, "Do you like it mmmmm that's nice isn't it, are you ready for some more?"

Supporting people to live healthier lives, access healthcare services and support
● People told us that they saw health professionals when they were not well.

●We saw that referrals to health professionals and GPs took place when people were unwell.

●A relative told us that their family member had lost some weight and what action staff had taken to respond to this.

●We saw that staff were generally calculating how much food and fluids they were giving people and how much people consumed. Although, people did not have targeted amounts with a direct plan of action of what to do if this amount was not consumed. We were told this was something which would be introduced.

Adapting service, design, decoration to meet people's needs
● The home supported many people who were living with dementia. The decoration and lay out of the home did not support people to orientate themselves to their environment. Dementia friendly decoration techniques and themes were not used to help orientate people and spark interest.

●Signage was confusing. In order, to avoid confusion and to aid independence we suggested the management team used signs that are made in one simple format only and all other signs are removed. To also use pictures on the signs as well as words.

We recommend the provider seeks advice from a reputable source about best practice in premises management for people living with dementia and updates their practice accordingly.

Staff support: induction, training, skills and experience
● New staff spoke positively about their induction to their new role. They told us that they felt supported by the senior staff and continued to feel supported by the staff team around them.

●New staff completed training and completed the 'care certificate' which is a set of standards which outline what good care is. Staff also received regular supervision. The registered manager told us how they checked that staff were competent post their induction, when they started to provide care more independently. This was positive, but no records were kept showing how senior staff and the registered manager verified staff were competent, at this point in time.

●All the staff we spoke with had undertaken some form of Dementia Training at a college. The staff we asked were also able to give examples as to what they had learned on these courses.

●The management team were completing audits to support staff to improve their skills and knowledge in

their work. This was also a checking system for the registered manager to see if staff were competent. We saw some observations completed, for example people's dining experiences. However, there were only four observations on personal care delivery completed since November 2018 and the registered manager told us that there was not a system to check staff in al key areas. We also saw records where staff had been asked to reflect on their practice in terms of treating people in an equal and fair way.

●During the inspection we observed good staff practice, but we also observed practice which needed improving. Therefore, we found that more work was required of the management team with how they monitored and responded to staff practice shortfalls.

Ensuring consent to care and treatment in line with law and guidance
● 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●We checked whether the service was working within the principles of the MCA. We noted that a professional was not adhering to one person's conditions of their authorisation. This had not been identified by the management team as part of their audits. We spoke with the management team about this who later told us what they had done about this.

●We did not find that people were being unnecessarily restricted in their movements. The service was assessing people's capacity to make decisions. Staff and some people told us how choice was promoted at the home. We concluded that the service was compliant with the MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● The people we spoke with spoke highly of the staff who supported them. However, we found short falls in how people were treated who spent all their time in bed in their bedrooms. The management team had not considered these people's experiences.

●These people had no real stimulation from staff. We observed staff not visiting these people to see if they were ok and did not spend any time with them. Even, when individuals expressed signs which meant they could be distressed or in need of something, staff did not respond. The management team had not considered if these people needed more support or if the support they received was caring and respectful. As a result of this we could not say that the service was caring to everyone who lived at the home.

●At times some staff were not always considerate towards people when they were trying to perform a task. We saw one example of a person being supported to be moved in a hoist while they were asleep. This person woke up suddenly while they were in the hoist and looked shocked and in discomfort. Staff had not tried to gently wake this person or engage with them.

● Other people however, had a different experience, and we can say for these people they felt the staff and management team were caring to them. One person said, "I feel so lucky to get all this attention, or shall I put it another way, I'm so lucky to be well looked after, the other day I wasn't well and didn't want to get up they [staff] kept bringing me cups of tea, and asking how I was, the staff are very respectful."

● Another person told us, "They [staff] are very kind to me."

● A person also told us about their experience of moving into the home. They told us about a previous care service where their experience had not been good. The person described how their family had helped them to move into their new home. The person said, "Now, it's the best place ever to me."

Supporting people to express their views and be involved in making decisions about their care
● One person told us, "There is nobody telling you when to go to bed I watch my television till I want to, I eat in my room or go to the dining room. They [staff] will always come and say would you like your lunch here or in the dining room, I please myself."

● Another person told us, "The [staff] will come and wake me up and say come on [name of person] it's time to get up, but if I say I am staying in be a bit longer they say ok we'll come back later."

● People were asked questions about their care. People's care assessments included evidence of who had been consulted with in planning their care such as, the person and their relatives.

Respecting and promoting people's privacy, dignity and independence
● People told us how staff promoted their dignity and privacy. One person said, "They [staff] will come to my room and knock on the door even if it is open… I can have a bath or shower whenever I like, they [staff] are very respectful. They [staff] do ask permission before they do anything."

●We saw a member of staff go up to a person who had fallen asleep in a lounge. They re-adjusted this person's skirt and put a blanket over their legs, while they slept.

●Throughout the inspection we saw staff being kind and caring towards the people they were supporting. We observed different staff speaking with one person throughout the morning. This person kept asking staff the same question. All the staff spoke in a kind and thoughtful way to this person.

We spoke with one member of staff about this person, they said. "[Name of person] is a lovely lady. I see the person and not the dementia."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

End of life care and support
● When we looked at people's care records we saw that people had end of life plans in place. However, these end of life plans lacked detail to support senior staff and the management team to plan for this part of people's lives and ensure people's wishes and preferences were always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● From looking at people's care records we could see that some work had been completed to identify and capture people's backgrounds, interests, and preferences. On the electronic record system in some cases this was limited.

●We spoke with two members of staff who did not know where to locate this information on their hand-held computers. However, we were told that people had more information in their paper records held at the home. Staff told us where these were. We asked staff when they last looked at this information and for whom, but they could not tell us. We asked a senior member of staff when they last saw a member of staff looking at these records, they could not tell us.

●Staff gave us a mixed response about the names of people they supported and their backgrounds, interests, and likes. Some staff were able to tell us something about the people they supported. However, some staff could not.

●Some staff told us that there was a key worker scheme in place (key workers are nominated staff with specific responsibilities for people's care), to help to get to know people better. Staff could not tell us who they were a key worker for. Despite this these staff gave us an example each about how they had connected to an individual at the home.

●The registered manager told us that in some cases people had limited interests and preferences recorded because they have a limited scope of interests. However, there had been a lack of progress to explore people's interests. This lack of documenting limited the provider's ability to identify what worked well for people and if changes were needed.

● The management team had introduced Positive Behavioural Support plans (PBS) for people living with dementia. This was positive that this process had started but these plans sometimes lacked details. Good detail would enable staff to intervene early and prevent behaviour escalating. PBS plans should not just inform staff what to do but how to do it and why they are doing it. However, this was not always the case.

● For people who were living with advanced dementia there was little stimulation for these people. Some

people stayed in their bedrooms all day and night. Some of these people were very confused and at times made sounds which could be because of distress. Apart from their TV's on one channel and a decoration hanging from the ceiling, they had no real regular stimulation or company. No work had been completed to review these people's experiences to see how it could be improved upon. No records were in place to evidence work had started in this area.

● Where people became distressed or anxious, there was a lack of information and guidance for staff to follow. We saw examples including one person who was ignored by five members of staff. One person was regularly making noises and looked distressed in their bed. For the time we were near this person we saw five members of staff walk past their open door, staff did not pop in to say hello or to check they were OK. Staff were not adhering to the person's care plan where 15 minutes' observations were planned for. One member of staff told us about the sounds the person was making, they said, "That is just how [they are]." Staff had become accustomed to this and were not responding to this person. When we entered the person's room and when one member of staff did this, this person stopped making these sounds.

● In one area of the home where people spent all of their time in bed, there was often a strong odour of faeces coming from a room where infection control waste was stored. This room did not have an extractor fan to dissipate this smell. There were no attempts made to make this a calm environment for other people. To consider different types of sensory engagement. To make people's life histories relevant and part of their daily life. To enable all staff to deliver dementia friendly support.

●In another situation relating to a person with similar needs living with advanced dementia who was in a communal part of the home. We saw one member of staff regularly go over and check they were OK by speaking with them. However, later in the day, this person was left making noises and banging their cup and no available staff spoke with them. Other staff passed through this area and said, "Hello, how are you?" to direct individuals, but staff did not wait to hear the reply.

●Another person looked agitated pulling their clothes protector off and pushing their plate away from them. A member of staff tried to help them to eat while they were visibly agitated. Which only escalated the issue. Eventually the member of staff said in a frustrated high tone, "Relax [name of person]."

●People who did not spend all their time in their bedrooms spoke highly of the activities and events which took place at the home. One person said, "If it's anybody's birthday they bake a cake and celebrate, I love the activities, I never get bored there is loads to do in here, we all got dressed up for the recent Royal Wedding, and we had a brilliant Christmas."

● Another person said, there was plenty to entertain them, that they loved the "Good old sing alongs, quizzes, making things, going to church." The person told us, "The activity lady is very good at telling us what's on. We get a paper to tell us all the things that are going on."

● We saw activities taking place in the lounge on the ground floor including daily pastimes such as fruit sampling, and a dog petting experience. There were two activity coordinators and for many events which had taken place and which were planned to take place in the future. We saw there was a chair-based exercise class and a singing session. People looked happy and were enjoying these experiences.

● In conclusion, further work was needed to meet and try and explore the needs of people who were living with advanced dementia. Staff skills and knowledge in this area needed improving to respond to people's needs in a person-centred way.

We recommend the provider seeks best practice advice from an organisation who are specialists in delivering dementia care and updates their practice accordingly.

Improving care quality in response to complaints or concerns

● We knew there was a process of managing complaints. Complaints had been handled effectively from when we looked at this at our last inspection of the home. We also saw compliments made by families.

● One person's relative told us, "We filled surveys every time they send us, I think it's every month. But the senior staff always ask us is there any problems. We asked them to try to take my relative for walk if the weather is nice if we are away. Yes, they do it."

● People told us that they attended monthly meetings where they could share their views of the home. These people also told us that they would speak with a senior carer if they wanted to raise an issue.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● We found that some people were not in receipt of person-centred care. The care that people received who stayed in their beds all day and night was not of a high standard. These people did not have regular support, attention, and the company of staff. Their rooms did not reflect their interests, backgrounds, what was important to them. Staff did not respond to their needs. The management team had not considered these people's experiences and tried to find ways to improve their time at the home.

● We found that work was needed to meet the needs of people living with different stages of dementia. In order to promote their independence and improve the quality of care they received. The management team had not sought the advice of other organisations to test how dementia friendly the service was and to make improvements.

● Key safety issues around the home were not being identified and dealt with. We found several issues which had the potential to compromise people's safety and make people unwell. These issues including maintenance issues and a lack of a schedule of maintenance and general up keep of the home. The management team were not aware of these.

● Good practice was observed from staff in terms of interacting with people, supporting them to eat and drink, assisting people to be moved using a hoist. Equally, however, we also found shortfalls in these areas at times.

● Audits were being completed by the management team and provider. However, they had not identified all the issues we found, and the management team was not working towards resolving them.

●During our engagement with the management team we found they did not respond as positively as they could have. This was more evident in the feedback session on the inspection day. We acknowledged that following the inadequate rating at the last inspection it had been a difficult time for the management team. However, during this inspection there were times when they were dismissive of our feedback and behaved in an unprofessional manner. For example, raising their voices. It was necessary to halt the feedback session on two occasions to enable them to compose themselves before continuing. Due to this we concluded that the management team did not always display an open and professional culture.

Working in partnership with others; Engaging and involving people using the service, the public and staff,

fully considering their equality characteristics

● In some areas we could see that the management team had started this process and we were told this by one professional who visited the home during the inspection. However, more work was required to ensure the service was meeting people's needs living with dementia, depression, and at the end part of their lives.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

● Staff had a good understanding about what abuse can look like and what they must do about it. There was a registered manager in place who has shown us historically that they have a good understanding of their regulatory responsibilities.

Continuous learning and improving care

● This process had started at the home. At our inspection in August 2018 we found infection control issues with slings. These had been resolved and people now have their own slings, to reduce an infection control risk. Skin creams and incontinence products were now being stored discreetly in people's rooms. Full recruitment checks on new staff have been completed. We received no concerns about poor practices of getting people up early as we had found last time. The dining experience had improved. There were now more competency checks in place for staff and opportunities to reflect on their practice.

●One person's relative told us, "The [registered] manger is very approachable, the home has improved greatly, not just in physical sense, with new floors and a whole wing re-decorated, but organizationally everything runs more smoothly. The staff have more time. I used to have the feeling some of them run about as headless chickens, now it's a calm atmosphere, they seem more professional."

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was always provided in a safe way. Regulation 12 (1) and (2) (d) (e) (h).