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Beech Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 4 April 2017. This was an unannounced inspection. Beech Court nursing home is registered to provide accommodation for up to 26 older people some living with dementia who require personal or nursing care. At the time of the inspection there were eight people living at the service.

The provider is registered with CQC as an individual and therefore it is not a condition of their registration that they have a registered manager in post. The registered provider has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 28 June and 1 July 2016, we found four breaches of the regulations. We asked the provider to take action to make sure people received safe care and treatment and to make sure people were supported in line with the principles of the Mental Capacity Act (2005). We also issued a warning notice telling the provider to improve their quality assurance systems. At this inspection on 04 April 2017 we found some improvements had been made, but improvements were still required in three areas.

People's mobility equipment was now stored in a way which kept it accessible in case of emergencies. People's records were kept confidentially and staff understood and respected confidentiality.

People had improved access to activities and stimulation from staff in the home. However, improvements in variety could still be made.

Since the inspection in June 2016 the provider had appointed a manager, who was not registered with the CQC. The manager had introduced some quality assurance systems, but these were not always effective at regularly identifying and driving improvements in the service. The provider did not operate any of their own quality assurance systems to ensure they were confident that they were delivering a high quality service. The provider demonstrated a lack of understanding of the regulations and how to implement good governance to ensure the regulations were met.

People were still not always protected from the risk of pressure sores as pressure relieving equipment was set incorrectly. Risk assessments and management plans were not always completed.

We also identified further concerns. People's medicines were not always stored safely. People's care records contained conflicting, inaccurate information and were not always person-centred.

Staff understood the principles of the Mental Capacity Act 2005. Where people were thought to lack capacity, some assessments in relation to their capacity had been completed However, these assessments were not always recorded in line with the principles of the MCA. Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

Beech Court has an extensive history of not meeting the regulations since registration in 2010. The provider has not made sustained improvements to the service to ensure people's safety and implement good quality assurance systems.

The provider followed safe recruitment practices. There were suitably qualified and experienced staff to meet people's needs. However, staff told us there were not enough staff to keep people safe. There was a significant amount of time when people sat during the morning with no staff interaction.

People who were supported by the service felt safe. Staff had a clear understanding of how to safeguard people and protect their health and well-being. People's medicines were administered safely.

People's nutritional needs were met. People were given choices and received their meals in timely manner. People were supported with meals in line with their care plans.

Staff knew the people they cared for and what was important to them. People's choices and wishes were respected and recorded in their care records.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

The provider informed us of all notifiable incidents. People and staff spoke positively about the management they had from the manager and provider.

We identified three 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 this 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.

Equipment used for prevention of pressure sores was not always set correctly.

Medicines were administered safely. However, medicines were not always stored safely in medicine fridges.

Risk assessments were not always fully completed and there were no clear management plans in place to guide staff on how to manage the risks.

There were suitably qualified staff to meet people's needs, however, staff told us, and we observed on one occasion, there were not enough staff to meet people's needs safely. There were periods were people went without staff engagement.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, mental capacity assessments were not recorded in line with the principles of MCA.

Staff had the knowledge and skills to meet people's needs. Staff received training and support to enable them to meet people's needs.

People were supported to have their nutritional needs met.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

Staff understood and respected confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed, however, care plans were not always accurate and contained conflicting. People's care plans were not always person centred.

People had access to activities, however, variety could be improved. There were periods were people went without staff engagement.

People knew how to make a complaint and were confident complaints would be dealt with effectively.

Is the service well-led?

Inadequate

The service was not well led.

The provider had a long standing history of not meeting the regulations.

The provider's quality assurance systems were ineffective and lacked oversight by the registered provider.

There was little evidence of provider oversight to address the concerns identified by CQC in previous inspections and ensure sustainable improvements had been made.

People and staff told us the management team was open and approachable.

Beech Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 April 2017 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We reviewed previous inspection reports. We also obtained feedback from commissioners of the service.

We spoke with three people and three people's relatives. We looked at four people's care records and three medicine administration records (MAR). During the inspection we spent time with people. Some of the people who used the service had communication barriers and because of this we were unable to fully obtain each of their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the provider, the manager, the head of care and staff which included two nurses, a carer and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 28 June and 1 July 2016, we found people were not always protected from the risk of pressure sores, as equipment was not always effectively used. We also found, people's mobility equipment was not always stored in a way which kept it accessible in case of emergencies. These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 4 April 2017 we found some improvements had been made. People's mobility equipment was stored in a way which kept it accessible in case of emergencies. However, people were still not always protected from the risk of pressure sores.

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One person's care plan stated they had a pressure relieving mattress that should be set at 40-50kg. The mattress setting was at 80kg. This put the person at risk of developing pressure sores. We spoke to the manager on duty who told us nurses checked the pressures in the mattresses and that managers also checked when they were on duty. The home manager said, "Pressure mattresses are checked daily by nurses and recorded on the charts". However there was no record of any mattress checks being completed. Two more mattresses had no guidance for staff to follow to ensure they were set correctly.

People's care records contained risk assessments which included risks associated with: falls; the use of bed rails; moving and handling; choking and pressure sores. However, risk assessments were not always fully completed and there were not always clear management plans in place to guide staff in how to manage the risks. For example, one person's pressure ulcer risk assessment (Waterlow) was not fully completed. The person's pressure area care plan stated "At risk of pressure areas being compromised as evidenced by Waterlow assessment". The care plan also stated, "To have pressure areas relieved by three-four hourly movement with use of hoist and sling when sitting in chair". We visited the person who was able to mobilise with the help of one member of staff and a walking aid. The person did not require support with a hoist to reposition.

People's medicines were not always stored safely. We found on more than 20 occasions in the previous three months, fridge temperature records indicated the fridge had reached temperatures of up to 14 degrees over the safe maximum limit of 8 degrees. There were medicines kept in this fridge. There was no

action taken when these recordings were out of range. The manager did not know the fridge temperature had been unsafe and had not reviewed the fridge temperature records as indicated in the provider's policy which stated 'If the fridge temperature is outside of the stated range (+2 and +8 degrees C) then assess the integrity of the stock in the fridge seeking pharmacist's advice where appropriate'. The manager told us, "Staff should have been reporting fridge temperature records".

During lunchtime, we saw one member of staff was present in the dining room. The member of staff was supporting one person to eat and drink away from the dining table. The person required constant supervision due to choking risks. The member of staff had to turn away from the person to attend to other people's needs. This posed a risk to the person who required constant supervision.

These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they had sufficient staff to meet people's needs. However, there was a significant amount of time when people sat during the morning with no staff interaction. Most people living in the home required assistance of two members of staff with personal care. On the day of the inspection there was a nurse and two care staff members on duty. Staff told us there were not enough staff to care for people safely. Staff comments included; "Night staff bring two people to the lounge at 7:30- 8:00. Everyone else is completely ready by 11:00", "Now we have eight residents I feel sometimes it's a bit tight at times. With six it was okay", "We could do with one more in the mornings so I can give more support" and "We do not have enough staff considering all our residents are double handed [require two member of staff to support them]".

People were not always confident there were enough staff to meet their needs. One person told us, "They could do with more staff. They come as quick as they can. It's worse at night". Another person said, "They have enough staff most of the time". One person's relative told us, "I visit very frequently and [person's] call bell is answered within five minutes".

The provider had an infection control policy in place. Staff understood their roles and responsibilities for maintaining standards of cleanliness and hygiene. We observed staff washing hands appropriately and using protective equipment effectively. However, there was an unpleasant smell in and around the lounge area.

People received their medicines as prescribed and the provider had a medicine policy in place which guided staff on how to give medicines safely. We observed staff administered medicines to people in line with their prescriptions. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. Staff had completed medicines training.

People told us they felt safe. Comments included; "Yes, I feel very safe" and "I feel safe. The nurses are very good. They are all good to me". People' relatives told us their relatives were safe living at Beech Court. One person's relative said, "[Person] looks safe. They ring me if they are worried about anything".

Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, fire and moving and handling. We observed staff using moving and handling equipment correctly and keeping people safe. People had personal evacuation emergency plans in place (PEEPs). These contained detailed information on people's mobility needs and additional support required in the event of a fire.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. Staff told us, "I would report to [the home managers]. I would challenge poor practice that is my role. It is my duty to keep people safe" and "I can report to safeguarding or CQC if worried".

People benefited from staff who understood and were confident about using the whistleblowing procedure. There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. One member of staff told us, "I could report above management".

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 28 June and 1 July 2016, we found the provider did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments. Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of Mental Capacity Act 2005 (MCA). These concerns were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection on 4 April 2017 we found some improvements had been made. Where people were thought to lack capacity, some assessments in relation to their capacity had been completed. However, these assessments had not been recorded in line with the principles of the MCA.

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked to see if people were supported in line with the principles of the MCA.

Care plans were not always completed in line with the principles of MCA. For example, one person's care plan had a best interest statement signed by a person's relative. However, the person had signed a consent form indicating they were able to consent to their care plan. There was no record of any capacity assessments being completed. We spoke to the person and they were able to tell us clearly about the support they needed. We spoke to the manager about this person's care plan and the best interest statement completed by the person's relative. The manager told us, "When [person] came here they were a bit unsettled so we weren't sure (about the person's capacity)". The manager also advised us no capacity assessment was completed in relation to any specific decisions.

We saw that consent was sought from people who did not have legal authority to consent on people's behalf. For example, one person's relative had signed a consent form relating to the use of bed rails. The relative did not have legal authority to consent on the person's behalf and there was no evidence of a capacity assessment and best interest process being completed.

Another person had covert medication care plan. 'Covert' is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. The care plan stated that 'a mental capacity assessment was undertaken and a multi-disciplinary best interest meeting held'. However, there was no record of either in this person's file. This was not in line with the principles of MCA.

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

We checked to see if the provider followed the requirements in the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. The MCA

DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. Applications under the DoLS had been authorised. People who had DoLS in place were being supported in the least restrictive way. Staff had been trained in the MCA and the specific requirements of the DoLS.

At the last inspection on 28 June and 1 July 2016, we found people's meal choices were not always respected and staff did not always record people's fluid intake. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection on 4 April 2017 we found improvements had been made. People were given meal choices and these were provided. Staff recorded people's fluid intake where people were at risk of dehydration.

People told us they enjoyed their food. Comments included; "Food is okay. Quite often we get to choose what we want", "The food is good, yes. The chef came to see me about lunch today. They are very good and give me what I want (to eat)" and "There is good food. We choose food at times to a certain extend".

Care plans detailed people's dietary requirements and we saw people received food and drink in line with the guidance. For example, one person required a pureed diet and thickened fluids. We saw the person was supported to eat a pureed meal at lunchtime and their fluids were thickened to the appropriate consistency. The chef was knowledgeable about people's needs and told us they visited people each day to discuss what was on the menu and what they would like to eat.

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently.

Staff were supported to access training and development opportunities. One member of staff told us, "I have done a lot of training. I have completed manual handling, fire and Mental Capacity Act. Now I am doing my level five diploma in management". However, there was no process in place to monitor staff refresher training needs. Staff were positive about the support they received. One member of staff told us, "I have supervision with [home manager], I can talk about any problems I have. I can also talk to [provider]". The manager told us they were in the process of revising their supervision policy.

People were supported to stay healthy and their care records described the support they needed. People had access to healthcare services and on-going healthcare support. For example, people had been supported by speech and language therapy (SALT), care home support service (CHSS) and their GP. One person told us they had been visited by their GP following increased pain and the GP was providing some additional treatment to manage the pain.

Good

Is the service caring?

Our findings

At the last inspection on 28 June and 1 July 2016, we found people's records were not always kept confidentially. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection on 4 April 2017 we found improvements had been made. People's records were kept confidentially and staff understood and respected confidentiality. Comments included; "We keep all documents in the nurses' office and lock the door" and "We don't discuss residents in public". People's personal records were kept in a key coded nurse's station only accessible to staff.

People complimented the care they received from staff. Comments included; "They [staff] are all very caring", "I like living here, they [staff] are good and kind" and "I'm looked after very well". People's relatives were positive about the care their family members received. One person's relative told us, "I am very satisfied with the level of kindness and care. They [staff] really care, you can pay people to do care but you can't pay them to be kind and they are very kind here".

We observed many caring interactions between staff and the people they were supporting during our inspection. For example, one person was becoming anxious. A member of staff approached them and knelt down to speak with the person. The person immediately relaxed and was smiling and chatting with the member of staff by the end of the interaction. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm. It was clear that staff had formed positive relationships with people and their relatives. Staff chatted with people, talking with them about their families and when they had visited.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us how they treated people with dignity and respect. Staff comments included; "We have to make sure we shut the door and the curtains and respect them as individuals" and "We have two ladies who prefer a female carer. Sometimes it's difficult, but they do understand".

People told us they were treated with dignity and respect. One person told us they preferred support from female carers and this was respected. People were dressed appropriately and looked well cared for. One person's relative told us, "[Person] is kept immaculately clean; this has helped her general health".

People were supported to be as independent as possible. Records showed people's independence was promoted. For example, one person's care plan stated 'Assist me with personal care. Allow me time to wash my hands and face'. Staff told us they encouraged this person to do things they could and assisted when required.

People and their relatives where appropriate were involved in decisions about end of life care and this was recorded in their care plans. For example, one person had an end of life care (a plan of their wishes at the

end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. Staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they would maintain people's dignity and comfort and involve specialist nurses in the persons care. One member of staff said, "We work with the GP and local hospice during end of life care planning and delivery".

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 28 June and 1 July 2016, we found people did not receive activities, stimulation or engagement which met their needs or preferences. We also found staff did not always engage with people and ensure care was person centred. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 4 April 2017 we found some improvements had been made. Staff engaged with people and people received some activities and stimulation. For example, we saw two people being supported by a private occupational therapist to make Easter decorations. The occupational therapist came to the service once a week to support some people with activities that interested them. We also saw pictures of people doing activities including baking, gardening and ball games displayed in the home. However, improvement could still be made to include more choice in activities. A persons' relative commented, "There is no activities variety in the home. There is no access to the garden". One person told us they did not like to join in activities with other people and preferred to spend time in their room reading and listening to music. The person received regular visits from relatives and was supported to walk around the home by a relative. The person's care record reflected that the person preferred to spend time in their room. One person told us, "I do scrap book and word search". A person's relative told us, "[Person] is in bed most of the time. Staff put on music that [person] likes".

Not all people's care records were accurate and some contained conflicting information. For example, one person's record stated '[Person] has been assessed as low risk of choking due to present health condition dementia related'. There was no information in the person's record to indicate they had a diagnosis of dementia. We spoke to the home manager who told us the person was not living with dementia. Another part of the person's care plan referred to a person by another name. It was clear that this information referred to a different person as the detail was about a health condition that was not relevant to the person's record we looked at.

These concerns were a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed before they came to live at Beech Court to ensure those needs could be met. These assessments were used to create a plan of care which included people's preferences and choices.

People and relatives confirmed they were involved in planning their care. People's records reflected their wishes and preferences. For example, people's preferences about what time they preferred to go to bed. One person's relative said, "We are involved in the care. They [staff] get in touch with changes and updates".

People's views and feedback was sought through family meetings. The home manager had held a relatives meeting to introduce themselves and encourage feedback about the service. Records of meeting minutes showed the manager had identified areas of improvement and advised relatives how these improvements would be made. For example, introducing cordless phones to aide better communication between people

and their relatives.

People and relatives felt confident to raise any concerns with the home manager or provider. One person said, "I can complain to the manager. I have done it before and it got sorted". One person's relative told us, "I would absolutely raise concerns. So far I have no issues. I have spoken with [provider] and [home manager] and they appear genuinely keen to make sure things are alright". The provider had a complaints policy in place. This was given to people and clearly displayed on notice board. Records of complaints showed there had been one verbal complaint since our last inspection. This had been logged in the complaints record and the outcome of the complaint recorded.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 28 June and 1 July 2016, we found people's records were not always complete and accurate. We also found the provider's audit and governance systems did not monitor or improve the quality of the service and did not remain effective. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served the provider with a warning notice. On this inspection on 04 April 2017 we found the provider had not met some of the requirements of the last warning notice which included poor record keeping as well as ineffective audit systems.

Following the last inspection the provider gave us an action plan covering a range of improvements they planned to make. The provider stated they were going to perform monthly mental capacity audits. We did not find any evidence mental capacity audits had been completed. The provider stated they would monitor pressure relieving equipment on a weekly basis. We found no evidence to demonstrate this was taking place. The manager told us they were in the process of introducing audits in these areas. The manager also commented, "Pressure mattresses are checked daily by nurses and recorded on the charts. We have recently purchased a few pressure mattresses as spare".

The provider had introduced some plans to improve the quality of the service. However, these plans were still not effective in identifying areas of improvement as well as actions to complete.

The provider's care plan audit dated 27 March 2017 had not identified any of the records issues we found such as incomplete and inaccurate risk assessments as well as risk management plans. The audit had not identified the care plans which had inaccurate and conflicting information. The audit also sighted a question 'Is there a capacity assessment in place?' and five out of six records were ticked. This meant these care plans had capacity assessment records in place. This was contrary to what we found during our inspection. This meant the provider's care plan audit was ineffective.

Another audit of activities on 28 February 2017 had identified the need for 'visiting entertainers or trips out'. The action was to set up an activity programme. There was no record of the action having been monitored to ensure that they were delivered.

The medication audits did not include fridge temperature checks where we found temperature checks were unsafe.

There was a procedure for recording accidents and incidents. Accidents or incidents relating to people were documented and actions were followed through to reduce the chance of further individual incidents occurring. However, there was no system in place to analyse or audit to look for patterns and trends and see if lessons could be learnt and changes made where necessary. We spoke to the manager who told us they were in the process of developing an analysis tool.

The provider did not understand the principles of good quality assurance. Since registration the provider has been served three warning notices on three different inspections for ineffective quality assurance

systems. All three warning notices had sighted poor record keeping and ineffective quality assurance systems. There was a longstanding history of this service not making sustained improvements. When we spoke with the provider about their governance and oversight at the service they told us they were relying on the manager at the service and visits from other organisations, such as the CQC or local authority, to identify areas for improvement. The service had been non-compliant with the regulations in the five previous CQC comprehensive (full) inspections.

These concerns were a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Beech Court was led by the provider and a manager who had been in post for five months, who was not registered with the CQC. The manager worked alongside a clinical manager who mainly worked on night shifts.

People we spoke with were complimentary of the provider and the management team. One person commented, "The home is well managed. [Manager] is very good and hands on". People's relatives were positive about the management of the home and felt they promoted an open culture that encouraged feedback. One person's relative said, "I find them [managers] approachable and I can contact them anytime"

Staff were equally complimentary about the management team. Comments included; "I enjoy my job very much. There is good communication and [managers] are very supportive" and "[Manager] is doing a good job. We have all new policies and we can find whatever we need in the office. [Manager] is trying to get things better and everyone is willing to support her".

The home manager had introduced regular team meetings to encourage feedback from staff. Records of one team meeting showed that a culture that was 'open and transparent and valued individuals' had been promoted.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care plans were not always completed in line with the principles of MCA. Consent was sought from people who did not have legal authority to consent on people's behalf. There were no records to show best interest processes had been followed for covert medicines. Regulation 11 (1)

The enforcement action we took:

Positive condition around recording on MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Pressure releaving equipment was not always set correctly. Risk assessments and management plans were not always completed. People's medicines were not always managed safely. Regulation 12 (2)(a)(b)(g)

The enforcement action we took:

Positive condition around medicines management, pressure sore risk assessments and risk management plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not always complete and

accurate.
The provider's audit systems did not monitor or improve the quality of the service.
The provider's audit and governance systems did not remain effective.

Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:

Positive condition around quality assurance .