Abbey Healthcare (Mill Hill) Limited

Abbey Healthcare- Aarandale Manor

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Aarandale Manor is a 65 bed nursing home providing personal and nursing care to 30 people aged 65 and over at the time of the inspection.

People's experience of using this service: People and their relatives in general were happy with the care and support that they received at Aarandale Manor. Some comments received were of a negative nature around insufficient numbers of staff and poor leadership.

The home did not have a permanent registered manager in place. A new manager had been recruited. In the interim the provider had implemented a management structure to support the home. Changes in management had impacted on the way the service was managed.

The provider and members of the senior management team overseeing the home were aware of the issues and concerns that the service faced around the quality of care and support that people received. Although an improvement plan was in place, the provider had been unable to implement the required improvements due to changes in management.

Risks associated with people's health, care and social care needs had not been assessed to enable the safe delivery of care for each individual.

Processes in place for medicines management and administration were not always appropriately followed to ensure people received their medicines safely and as prescribed.

People's care needs and preferences were not clearly understood by care staff. Care plans were disorganised and key pieces of information were not always clearly available to find.

Care plans were person centred and gave information about people's lives, their likes, dislikes and preferences. However, due to the way in which care plans were structured, this information was not always easily accessible.

People and their relatives told us that they felt safe and secure living at Aarandale Manor. Care staff understood their responsibilities around safeguarding people and the steps they would take to report their concerns.

The service had made improvements to ensure that all staff were regularly supported through training, supervisions and annual appraisals.

We observed some very positive and caring interactions between people and care staff. However, we also observed some negative interactions. Practices seen did not always demonstrate a good awareness of appropriate dementia care.

People were observed enjoying their meals and were given a choice of what they would like to eat and drink. Snacks and drinks were readily available and offered to people throughout the day.

People were supported and encouraged to participate in a variety of activities organised within the home. The environment was supportive of people living with dementia. Appropriate signage had been used around the home to support people to orientate around the home and maintain their independence.

People and their relatives knew who to speak with if they had a complaint or concern to raise and were generally confident that their concerns would be appropriately addressed.

More information is in the detailed findings below.

We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment and the governance of the service. Details of action we have asked the provider to take can be found at the end of this report.

Rating at last inspection: At the last inspection the service was rated Requires Improvement (report published February 2018). This service has been rated as Requires Improvement for the second time.

Why we inspected: This was a planned inspection based on the rating at the last inspection. At this inspection we found that whilst some improvements had been made around staff training and support, we continued to find further areas of concern that required improvement.

Follow up: We will ask the provider to submit an action plan detailing the steps they intend to take to ensure the required improvements are implemented. We will also continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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.
Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Abbey Healthcare- Aarandale Manor

Detailed findings

Background to this 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: This inspection team consisted of two inspectors, a specialist advisor nurse, a specialist advisor pharmacist and three experts-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.

Service and service type: Aarandale Manor 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. Aarandale Manor can accommodate up to 65 people in one adapted building.

At the time of this inspection there was no registered manager in post. The regional director was overseeing the management of the home. A registered manager had been recruited and was due to take up position in the coming weeks. Where a registered manager is in post, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection, we reviewed the information that we held about the service and the provider including notifications affecting the safety and well-being of people who used the service. We had also received monitoring information from one local authority. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at

the action plan that the provider had submitted following the last inspection in December 2017 which listed the improvements they planned to make.

During the inspection we spoke with 14 people using the service and 15 relatives to obtain their feedback on the care and support that they and their relative received. We also observed interactions between people and care staff which included the delivery of care in practice.

We spoke with ten care staff, two nurses, one care home assistant practitioner, the activities co-ordinator, the deputy manager and the regional director. A care home assistant practitioner is a worker who has been trained to competently deliver health and social care, which can include certain nursing tasks for people.

We looked at the care records of eight people who used the service and medicines administration records (MARs) and medicines supplies for 32 people. We also looked at the personnel and training files of seven staff. Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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.

Assessing risk, safety monitoring and management
• Risks associated with people's health and care needs had not always been assessed to ensure that people were supported and cared for safely. Care plans contained information and guidance about certain identified risks such as skin integrity, malnutrition, moving and handling and falls. However, where people had identified risks associated with specific health conditions such as diabetes and epilepsy, information and guidance was not available for care staff to support people to minimise or mitigate these known risks.
• Care plans for people who presented with behaviours that challenged, did not contain sufficient information and guidance for care staff on how to respond to those identified behavioural risks.
• For one person we were told that they had been placed on fluid restrictions due to a specific health condition. The person's care plan did not contain any further information in relation to their condition, any associated risks and why a fluid restriction had been put in place.
• Where risk assessments were in place, some of these had not been reviewed or updated to reflect people's current needs and requirements.
•People had personal emergency evacuation plans in place which described how to support the person safely in an emergency.
• The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems were undertaken.

Using medicines safely:
• Records used to document and support the safe management and administration of medicines were not always fully completed. Medicine Administration Records (MARs) were generally complete and we did not see any significant omissions in recording. However, during the inspection, for two people, their medicines had not been recorded as given. We checked the Monitored Dosage System (MDS) and found the tablets had been dispensed. MDSs are pre-packed boxes, normally prepared by a pharmacist, for each time the medicine is required.
• Some people may not have been receiving their medicines as prescribed. We checked stock levels of medicines that were provided in their original packaging to see if they had been given as prescribed. On the second floor we found several discrepancies between what had been administered and the number of tablets that remained. This included medicines to protect the stomach, prevent seizures and for agitation.
• Most people who had been prescribed medicines to be administered on an 'as and when' (PRN) basis, such as painkillers, had protocols in place so that staff could identify when they were in pain and give the appropriate treatment. However, on the second floor of the home, some PRN protocols were not available.
• Some people received medicines which were disguised in food or crushed. Records confirmed that the home had sought advice from the community pharmacist and that multidisciplinary agreements were available in the person's care plan. However, documents confirming this were not available with the MAR on

the second floor to facilitate safe administration of medicines.
• We saw that medicines were generally kept securely. We looked at controlled drugs and saw that balances were correct. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971. However, we did see that the controlled drugs cupboard was not sufficiently secure and did not meet The Safe Custody Regulations.
• Monthly medicine audits had been completed but did not always identify the issues we found as part of the inspection. Where issues were identified actions had not been taken to address the issue and make the necessary improvements.
• Although we found issues around people receiving their medicines safely and as prescribed we did note positive practices in place which supported safe management and administration of medicines. These included completed records for people on how to administer their medicines, any known allergies and completed charts for the administration of prescribed creams and patches.

The lack of clear guidance and poor practice around medicines and managing risk meant people were at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• People and their relatives told us that they felt safe and secure whilst living at Aarandale Manor. One person told us, "I feel safe. They know what you need. They help you straight away." Another person said, "I like to live here, a very safe place." One relative told us, "I feel my wife is safe here. My [relative] wanders around at night. There is a sensor in her room, so they know when she gets up."
• Care staff were able to explain ways in which they recognised any signs of abuse and the steps they would take to report their concerns. Care staff understood how to whistle-blow and named agencies they would contact to do this.
• Effective processes were in place to ensure all safeguarding concerns were reported and investigated to ensure people were always protected and kept safe from abuse.
• All accidents and incidents were documented with detail of the incident, actions taken and any further follow up required to ensure that appropriate improvements and learning could be considered to prevent any future re-occurrences.
• Daily handovers and staff meetings were used to communicate learning and improvements with all staff, about all accidents and incidents that had occurred.

Staffing and recruitment
• Processes in place enabled the service to recruit care staff that had been assessed as suitable to work with vulnerable adults.
• Throughout the inspection process we observed there to be sufficient numbers of staff available to support people safely. However, feedback from people and their relatives was mixed with some stating that there were not always enough staff available and that there were occasions where people had to wait to be assisted. We highlighted this to the regional director who stated that they would look into the appropriate deployment of staff to ensure their availability at all times.

Preventing and controlling infection
• Care staff had received training on infection control. Care staff had access to personal protective equipment to prevent and control the spread of infection.
• We observed that the home was clean and free from malodours.
• We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed.

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.

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

Staff support: induction, training, skills and experience
• At the last inspection in December 2017, we found the service to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care staff did not receive the appropriate training and support to carry out their role.
• During this inspection we found that the service had made the necessary improvements in these areas. Training records confirmed that each staff member received a period of induction, shadowing with an experienced member of staff and on-going training in topics applicable to their role.
• People and their relatives told us that generally care staff knew how to do their jobs and supported them and their relatives appropriately. When asked if staff were skilled to do the job, one relative told us, "Yes I do they are very kind to him." Another relative said, "Some are, some aren't mostly they know what they are doing, not everyone. They've got some very good staff up there at the moment."
• Most care staff told us that they felt supported in their role and had received supervision which they found to be effective. Care staff told us that they were able to discuss any concerns or issues that they had.
• Appraisals for all staff were yet to take place. Most staff had not completed a full year of their employment. The regional director had plans in place to ensure all care staff received their annual appraisal over the coming months.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• The service carried out an assessment of people's needs to confirm that the home could effectively meet their needs and choices.
• A care plan was then compiled so that care staff were given clear information and guidance on how the person wished to be supporting taking into consideration any risks, special needs and requirements.
• However, care plans were disorganised and important information about the person, their needs and preferences was not always easy to find which meant that people may have been placed at risk of not receiving effective care and support.

Supporting people to eat and drink enough to maintain a balanced diet
• People and their relatives were overall complimentary of the meals provided at the home. People's feedback included, "The food is good. You get a choice. Everything is very nice" and "I like what I get. It is quite sufficient and not boring." One relative explained, "[Relative] has not complained to me once about the food since he had been there he never seems to be hungry. He goes for a walk about in the night and they always ask him if he wants a sandwich or something so they look after him in that respect."
• We observed people being supported to eat and drink with dignity and respect whilst encouraging people to maintain their independence where possible. Drinks, snacks and fruit were available to people

throughout the day.
• Where people had special dietary requirements these had been clearly documented in the person's care plan and kitchen staff were aware of these to ensure people received safe and effective care according to their needs.
• However, we did note that charts to record and monitor people's food and fluid intake were not always consistently and fully completed. This meant that people at risk of malnutrition or dehydration may not have received the care required because charts had not been fully completed and any arising concerns may not have been identified. This was highlighted to the regional director who gave assurance that this would be addressed immediately.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Records confirmed that the service tried to work effectively as a team within the home as well as in partnership with other agencies so that people received effective and consistent care.
• Daily handovers and 'flash meetings' for managers within the home supported effective information exchange about people and their health and care needs. We saw records between the service and a variety of health care professionals where people required specialised intervention.
• People and their relatives confirmed that the home arranged access to health care professionals including GPs, dentists, opticians and dieticians. One relative told us, "Yes, when I went in there and they were concerned about him the doctor had already been. Although the doctor had been in the day before they called him out especially to see my [relative]."

Adapting service, design, decoration to meet people's needs
• All areas of the home were accessible by people including the garden and outdoor spaces. Appropriate signs were available throughout the home to enable people to find their way around and locate their bedrooms and toilet facilities.
• The second floor had been adapted to accommodate people living with dementia. The provider had used appropriate decoration and signage to support this and promote people's independence.

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 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• We found that although the service was working within the principles of the MCA, DoLS authorisations and any applied conditions had not always been clearly recorded in the person's care plan. Therefore, where conditions may have been set, care staff would be unaware of this and how to support the person to meet the conditions.
• People's care plans contained mental capacity assessments for specific decisions that needed to be made

in people's best interests. These included decisions made for areas such as consenting to bed rails, medicines to be administered covertly and supporting with personal care.

• We observed that people were always asked for consent before being supported by care staff in all aspects of their daily living. However, consent to care and treatment had not always been clearly documented in the person's care plan. People or their relatives had not always signed the care plan confirming their consent or involvement in the planning and delivery of care.

• Care staff demonstrated a good understanding of the key principles of the MCA and how these were to be applied when supporting and caring for people. One care staff told us, "I try to figure out what people need and want and what they want to do. I can see them and understand their signs and expressions. I always give choice and ask permission."

Good

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• People and their relatives found that care staff at Aarandale Manor were kind and caring. People told us, "Everyone is kind. It's like you would have at home. I can't fault them for anything. Everybody wants to do things for you. They are lovely", "The staff are marvellous in every way" and "It's very good here. Everything is there waiting for me. The staff are very good."
• Relatives feedback included, "The staff will sit with [relative] and hold her hand. They know she can be difficult in the mornings. If she's upset someone sits with her", "We are bilingual, so they will speak Spanish to him. They are caring and loving" and "Oh extremely caring, they are so patient they are popping into the room asking does he want a biscuit does he want a cup of tea."
• We observed throughout the inspection kind and caring interactions between people and care staff. Care staff knew people really well and knew how to support them according to their needs and wishes.
• Care plans listed people's religious and cultural beliefs and any specific wishes they had to support their beliefs. For one person, their care plan recorded that they wanted to wear a specific head dress and we saw that the person was supported to wear this. The service arranged visits from the local church and Jewish community so that people could be supported to practice their faith.
• People were supported to maintain their relationships with their partners, family and friends. Visitors were welcome to the home at any time. Care plans gave some basic background information on people's current relationships. However, this could be expanded on so that further detail on people's sexual needs and how they wished to be supported with those needs were known by the service and care staff.
• Care staff understood people's diverse and cultural needs and were keen to ensure that care provision was non-discriminatory and that people were supported according to their needs and preferences.

Supporting people to express their views and be involved in making decisions about their care
• We observed that people were involved in making decisions about their daily living and care needs where practicably possible.
• Care plans detailed people's likes and dislikes, needs and preferences which care staff were aware of and were observed supporting people accordingly.
• Relatives confirmed that they had been involved in care planning and had been asked to provide personal information about the person to help enhance their experience of care.

Respecting and promoting people's privacy, dignity and independence
• People and their relatives confirmed that they and their relative were always treated with dignity and respect. One person told us, "Your privacy is respected. I have never had any problems over my personal care." A relative told us, "Staff always treat [relative} with respect, the most important thing."

• Care staff understood the importance of respecting people's privacy and dignity and supported them in maintaining their independence where possible. We saw care staff encourage people to try and undertake certain tasks themselves only intervening where required. Care staff also gave us examples of this in practice. One care staff told us, "I knock their [people's] door and enter their room and I close the curtains to ensure privacy." Another said, "They [people] tell us what they want and we do."

Requires Improvement

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans were person centred. People's likes, dislikes, preferences and wishes had been recorded so that care staff were able to provide care and support that was responsive to their needs.
• However, this detailed and personal information was not easy to locate as the setup of the care plan was disorganised, which meant that significant and important information about people and how they wished to be supported was not easy to locate. This meant that people may not have received care and support that was responsive to their needs.
• On the second day of the inspection the regional director had made significant improvements to the format of the care plan following our feedback. We saw two examples of updated care plans which were easy to follow and understand. The regional director assured us that following the inspection all care plans would be reviewed and updated to the new format.
• Care plans were reviewed on a monthly basis or sooner if concerns or change had been noted.
• We observed that all care staff communicated with people in ways which were responsive to each person's individual personalities and communication needs. People knew the care staff well and vice versa and this was demonstrated through interactions and conversation between them.
• However, we did note some interactions that were not so positive and did not demonstrate good dementia care. One observation included three senior members of staff trying to communicate with one person, who had suddenly become unwell. This further confused the person who was not responding. Interactions seen did not promote the person's well-being. Feedback about our observations were given to the regional director who assured us that this would be looked at as part of their audit processes.
• Throughout the inspection we observed people participating in activities which included a sing along, a quiz, a ball game and some art work. People and their relatives told us that there were a variety of activities that were organised and people had a choice whether or not to take part.
• An activity board displayed in each area of the home, listed a variety of daily activities which included exercise, ball games, quizzes, sing along, story-telling, entertainers, pampering sessions, card games, movement and exercise session, singing and dancing. Records listed the activities people had taken part in alongside photos of them in action.

Improving care quality in response to complaints or concerns
• People and their relatives told us they felt confident in raising their concerns and complaints and knew who to speak with to do this. One person said, "If I had a problem I would ask one of the girls. They would sort the problem out." One relative told us, "Definitely, [names of senior manager], it depends what it is about. The doors of the office are always open." Another said, ""I just go down and speak to whoever is in charge. I tell her [manager] and she sorts things out, they do try their best to sort things out."
• Complaints were clearly recorded, investigated and responded to by senior managers in line with the provider's policy. The service demonstrated an open and transparent approach to dealing with complaints

with a view to learning and making the required improvements.

End of life care and support
• Care plans included a section on end of life wishes, however, these were not always fully completed. Personalised detail about how the person wished to be cared for at the end of their life had not been explored with the person or documented. For three care plans that we looked at there was no completed end of life care plan. For another two people, end of life wishes had not been expressed.
• We did note that where people had made the advanced decision to not be resuscitated, this had been clearly documented within their care plan. Records showed healthcare professionals, people and relatives had been involved in these decisions. The provider had ensured this information would be readily available to staff.

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.

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

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

• At the last inspection in December 2017 we identified issues with how the service improved and learnt from issues and concerns that they identified.

• At this inspection we found that although the senior management and the provider were aware of the issues and difficulties that the service continued to face and improvement plans were in place, sufficient improvements had not been progressed since the last inspection to ensure people were receiving safe and responsive care.

• People's individualised risks had not been fully assessed to ensure care staff knew how to minimise or mitigate the risk to keep people safe; people may have been at risk of receiving their medicines unsafely; consent to care had not been clearly documented; care plans were disorganised and poorly structured.

• Although some progress had been made with making improvements to the home, the pace was very slow and had been impacted by the changes in management and the lack of a permanent manager in post. This had affected the quality of care that people received and staff morale.

• Some relatives told us about the lack of stable management and that this had not been good for the home. One relative told us, "The changes of management and staff have impacted on people here. The care of residents has been compromised enormously." Another stated, "There has been recent management change so the jury is still out."

• The regional director explained that senior managers within the home continued to work towards ensuring that people received good quality care. She said, "Constant changes with management hasn't helped. We need someone who will own the home." A new manager had been recruited and was due to be in post at the end of February 2019.

● However, the concerns we continued to find at this inspection meant that people were placed at risk of receiving care that was not safe, effective and responsive to their needs.

The range of concerns and the failure of the provider to systematically address them is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• People and their relatives knew the senior management team and felt able to approach them to raise their concerns. One person told us, "[Name of management team member] is in charge, she is a decent lady, I like her." One relative said, "I think they are improving all the time. Whatever is brought to their attention they deal with. Management is very good."

• People and their relatives felt that communication between them and the home was open and transparent. One relative told us, "I do feel consulted. They would contact me if [relative] wasn't well or if she had any sort of accident. I have never come here and found something I hadn't been told about."
• Staff generally told us that the current management support was good and that they were listened to when they raised any issues or concerns. Feedback included, "A lot of manager changes. It's hard for us to get used to", "It's okay, management need to find their feet. Apart from that it's okay" and "Management is supportive. All places have issues. We are trying to work together to solve the issues."
• Regular care staff meetings and heads of department meetings encouraged effective communication and gave staff an opportunity to raise concerns, make suggestions and share good practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● People and their relatives were engaged in giving their feedback and suggestions for improvement through the annual and ad-hoc completion of satisfaction surveys. We saw surveys that had been completed around meal provisions at the home as well as overall surveys about the quality of care.
• Residents' and relatives' meetings were also held regularly which enabled the service to exchange information about the home and its services and provide updates about significant events and plans. People and their relatives stated that they felt confident in raising issues and making suggestions. One relative told us, "They have relative meetings in the past and I have been to a couple of them, they hold them periodically." Another said, "We are invited for relatives meeting."
• The senior management team always encouraged feedback from people, relatives and visiting professionals so that improvements could be continuously acted upon to further learn and develop the service.

Working in partnership with others
• The service engaged and worked well with the local authority quality assurance team to implement the required improvements to the quality of care that people received.
• The service also worked in partnership with other health and social care professionals including the palliative care team, GPs, opticians, dentists, dieticians and continence advisors.
• The service had good links with the local community and the provider worked in partnership with them to improve people's wellbeing. We saw examples of visits to the home by children from a local school who would interact with people. Regular involvement from community groups such as the local church, local faith groups and visits from pets had also been organised.

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 Identified risks associated with people's health and medical needs had not been assessed so that staff could be provided with guidance on how to mitigate risks so that people were kept safe and free from harm. Medicines were not always managed, administered and recorded safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems for improving the service were not operating effectively to identify and address issues with the quality and safety of the service.