Interhaze Limited

The Hunters Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit was unannounced and took place on 26 July 2017. At our last inspection visit on 30 June 2015 we asked the provider to make improvements to their as required medicines and safety of the environment. At this inspection, we found improvements had been made, however we identified some areas of concern in relation to how a decision is made when a person requires covert medicine and in the auditing of information to drive improvements to the home.

The service was registered to provide accommodation for up to 92 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 86 people were using the service.

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

The registered manager had not always used their audits to reflect the running of the home and we saw there were areas which would have benefited from a robust process of checks for medicines and accidents information. When agency staff had been used, the necessary checks had not been completed to enable them to have the information to support people and their needs.

When people were unable to make decisions, about taking their medicine covertly, a best interest decision had not been completed. However when other decisions were required we saw that an assessment had been completed and people lacked capacity, and best interest decisions had been completed. Where people were being restricted of their liberty, the appropriate authorisations had been applied for.

People were not always supported to maintain their independence when they ate their meals, equipment and types of crockery had not been considered. People enjoyed their meals and had a choice of what they wished to eat. Their health care was monitored and when required referrals had been made to health care professionals. Any guidance received was implemented and the care plans updated with this information.

There was an opportunity for people and their relatives to give feedback on the service; the registered manager had also provided a range of opportunities to engage with relatives, however there had been limited response to these events. The registered manager was considering other opportunities and ways to ensure information was available.
Staff had received training in a range of areas to support their role and staff had the opportunity to progress with the home. People who used the service felt safe and staff understood their role in ensuring people were protected from harm. Staff recruited to the home had received the appropriate checks to ensure they were safe to work with people. Risk assessments were in place to ensure people's safety and the safety of the

environment. There were sufficient staff to support people's needs and this was kept under constant review to ensure the staffing levels reflected people's needs.

People had established positive relationships with the staff felt their decisions were respected. Staff had a kind and friendly approach to the care they delivered. People had the opportunity to engage in activities and entertainment was provided.

Medicines were managed safely and staff had received training and competency checks. People enjoyed the meals and had the opportunity to choose the food they ate. People felt relaxed in the atmosphere of the home and confident they could raise any concerns with the registered manager.

We saw that the previous rating was displayed in the reception of the home as required. The manager understood their responsibility of registration with us and notified us of important events that occurred at the service; this meant we could check appropriate action had been taken.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe
People's individual risks were identified and managed. Staff were suitably recruited and understood how to protect people from harm and poor care. Medicines were managed to ensure safe administration. There were sufficient staff to support people's needs, which was flexible to support he needs on each unit. There was a safe recruitment processes.

Is the service effective?

Requires Improvement

The service was not always effective
The provider had not always considered when people were being unlawfully restricted and taken the appropriate steps to follow guidance. People were not always supported to be independent with their meal. They enjoyed the food and had been supported to make decisions. Specialist advice was sought promptly when people needed additional support to maintain their health and well-being. Staff had received training which gave them the skills they needed to care for people effectively.

Is the service caring?

Good

The service was caring

People and their relatives were happy with the care that was provided. It was delivered in a dignified and respectful way. People were encouraged to make choices and be independent. Relatives and friends were free to visit throughout the day.

Is the service responsive?

Good

The service was responsive
People received care which met their preferences and staff understood their likes and dislikes. There were opportunities for people to choose how they spent their leisure time. There was a complaints procedure and this was followed when required to address any concerns.

Is the service well-led?

Requires Improvement

The service was not always welled

Effective systems were not always in place to assess, monitor and improve the quality of care. When agency staff were used the relevant checks and inductions had not always been completed. The provider monitored the home and people and relatives were encouraged to share their opinion. The registered manager had developed opportunities to engage with relatives and planned to cascade information in a range of formats to ensure information relating to the home was available. Staff received support and felt able to develop their roles on each unit.

The Hunters Lodge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection visit under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Our inspection was unannounced on 26 July 2017 and the team consisted of three inspectors, an expert by experience and a specialist advisor. A specialist advisor is a professional who has expertise in a specific area; our specialist had knowledge and expertise in care for people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. We also spoke with the local authority who provided us with their current monitoring information. We used this information to formulate our inspection plan.

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

We also spoke with eight members of care staff and three nurses, two unit manager and the registered manager. We looked at the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. We looked at the care records for eleven people to see if they were accurate and up to date. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Good

Is the service safe?

Our findings

Our previous inspection in June 2015 we found that whilst the provider was not in breach of any regulations, there were aspects of care that could be improved to make people using the service safer. We reported on these in our last report. During this inspection we found that the provider had taken note of our comments and had made the required improvements.

People received support with their medicine. One person said, "I have a lot of different tablets some for my memory which is failing, happy with staff giving them me." Another person said, "Staff give me my medication, that's why I came here, I messed it all up." At our last inspection we identified there were no protocols in place for as and when required medicine, we saw that protocols were now in place. People were offered a drink with their tablets, an explanation of the medicine and time to take them. When they had taken their medicine it was recorded on a medicine administration form.

The staff had received training in medicine administration, and we saw they had observed practice to ensure they were following the correct procedures and guidance. One staff member said, "I was able to shadow the staff, it was really good and I was able to take my time so I got it right." When there had been medicine errors the registered manager had ensured the staff member received additional training and further competency checks before being able to administer the medicine independently. This demonstrated there were processes in place to ensure the management of medicine was safe.

At our last inspection we raised a concern around the environmental risks. We saw these had been addressed with the kitchen areas being sectioned off with a door and a key pad entry. Environmental risks were assessed to ensure that people were protected. We saw that fire procedures were clearly displayed. Plans were in place to respond to emergencies, such as personal emergency evacuation plans. These plans provided a picture of the person and guidance on the level of support each person would require to be evacuated in an emergency situation. We saw these plans had been updated when a person's needs changed.

The provider had several maintenance staff. They ensured that repairs were completed swiftly to avoid any disruption or delay in care for people. The maintenance of the premises was routinely checked and when repairs where required, we saw that an action plan was developed with the registered manager and monitored until they had been completed.

The care plans reflected individual risk and provided guidance to staff how these could be reduced. For example, we saw some people chose to smoke. Each person had their own risk assessments which reflected any risks relating to the use of a lighter and the frequency of having a cigarette. The frequency reflected the individual's preference and any related health concerns. Where the person required equipment this was assessed individually, identifying the equipment to be used and any specific needs of the person. For example, the use of equipment to adjust the person before they had their meals, to reduce the risk of choking. One person said, "My personal care is wonderful, no other word for it, so kind, lot better off here, all nice staff." We observed staff using equipment to transfer people, this was carried out safely with the staff

member providing encouragement and reassurance.

Some people expressed their emotions through behaviours that could challenge and these may impact on their safety and that of others. We saw there were risk assessments in place which provided guidance for the staff. Any incidents had been recorded to consider any triggers; they also showed any interventions provided and how they had maintained the safety of people.

People were protected to maintain the integrity of their skin. We saw that people were monitored regularly to record any concerns. A staff member told us, "We check the integrity of the person's skin by using the 'blanch test,' if we have any concerns we report it." The blanch test is a simple check on the skin, where slight pressure is applied to a reddened area, the skin should go white and return back to pink within a couple of seconds when the pressure is released. If the area stays white then the blood flow is impaired and damage has begun, early intervention at this stage should see the area recover in 2-3 days. We saw that people who remained seated received regular pressure relief by the use of equipment or agreed bed rest. Some people had difficulty standing and moving. We saw staff were patient and offered encouragement where needed. We saw these people were appropriately supported and encouraged were provided with patience.

People told us they felt safe when they received care. One person said, "I feel safe due to staff walking around, they smile and ask if I'm alright and anything I want." Another person said, "I feel safe here, someone is here all the time, I'm not on my own." Staff had received training in safeguarding and understood the different signs of abuse and knew how to raise a concern. One staff member said, "If there are unexplained bruises, I would check if it's been documented and then report it." Another staff member knew about the importance of raising a concern if two people had a disagreement, they said, "We have to make sure everyone is looked after in the correct way and raise a concern if needed." Where potential harm had been identified this had been reported to the local authority under agreed safeguarding procedures and we had been informed of these alerts. We saw investigations had been completed and actions taken to ensure the people remained safe from harm.

There were sufficient staff to meet people's support needs. One person said, "Always enough staff, if you need help, they put themselves out for you." They added, "Always staff wandering around." Another person said, "Enough staff about when I need them and all very good." Staff felt there were enough staff, one said, "We have enough and it's flexible so we can increase if needed, dependant on people needs." Another staff member said, "Staffing is generally okay for the people's needs with less agency staff being used and with the on-going recruitment." We saw that the registered manager had a dependency tool to review the level of staff on each unit in relation to the people's needs. We saw that on one unit they were trialling the addition of a staff member starting earlier to support the transition of the morning time. One staff member said, "This is to help with the smooth running of the change over, I feel it gives us more time with people." On another unit planned to introduce another staff member for the nights. The manager said, "This is to support the staff as they work over two floors and people can be unpredictable." This demonstrated that staffing levels were kept under review to ensure there were enough staff to meet people's needs at all times.

We saw that checks had been carried out to ensure that the staff were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

Some people required their medicine to be given to them covertly. Covert medicine is when the person receives their medicine without their knowledge. We saw the form on the medicine file was signed by the relative and GP giving permission for the medicine to be given in this way. There was best interest meeting to identify how the decision had been made or any protocols to identify when or how the medicine should be given. Relatives had signed a form giving the home permission for a covert approach to be considered, however there was no evidence to show that the relative had the legal power of attorney to make this decision. Information in the person's care plan had identified they lacked capacity to make decisions, we saw no best interest meeting had taken place to clarify the reason for the decision to be made. This showed the provider's approach to supporting people with decision making was not consistent.

We recommend that the provider researches current guidance on best practice relating to covert medicine when people living at the home do not have capacity.

We saw that in all the units for other decisions assessments had been completed which were specific to the activity or decision. For these areas of decision we saw that best interest meetings had been completed and the relevant people consulted in relation to the decision. Applications relating to DoLS had been completed to the relevant authority. We saw when a condition had been placed on the DoLS, staff were aware of the condition and ensured it was reflected in the person's care plan and recorded. The DoLS records identified when specific techniques maybe used, for example when restraint was required. Clear guidance was detailed in the care plans and records maintained when any restrain had been used. Staff had received training in the use of these techniques and training in the Act and DoLS. Staff we spoke with were able to identify people who had a DoLS authorised and any condition associated with it. One staff member said, "It's reflecting what's in the persons best interest, for example some people are not safe to leave the building." We saw in each unit staff asked people their consent before support was provided.

Some people required support with their meal. We saw this was provided by staff, however they stood at the side of the person which did not provide a personal approach. Staff had not considered the use of another chair to enable them to be at the same level as the person. The manager told us they had ordered some stools for the staff, however they had not yet arrived. In one unit we saw that some people had to wait for

their support. For example, one person had fallen asleep; they were woken by the staff and given their dinner. The person then went back to sleep. They were woken forty five minutes later and offered the same meal. The plates used for people's meals were plastic and therefore the food was not able to retain its heat. The manager told us the type of crockery used was a decision by the provider. We observed that no one on the units had been offered the use of equipment to aid their independence with their meals. For example, one person had their fork loaded with large pieces of food which they had been unable to cut independently and had not been offered assistance. Other people were slow to eat as they struggled without the support of a plate guard. This meant we could not be sure people received a positive meal experience and encouraged to be independent.

People enjoyed the meals. One person said, "Food is marvellous, all good food, you can have as much as you like and there is a good choice." Another person said, "Meals are very nice, I only like a little and you can choose." Hot drinks, juices and milk shakes were served throughout the day and people were offered snacks, which were encouraged. Some people required thickeners for their drinks, where this had been added staff explained why 'this is prescribed by your doctor to help you to swallow, is that okay ?'

We saw that people's weight had been monitored and records kept which reflected the amount people had eaten and their fluid intake. When there was a concern about a person we saw referrals had been made to the speech and language team (SALT) who had provided an assessment and made recommendations. We saw this had been implemented and reflected in the persons care plan. For example, a person was having difficulties with swallowing; they are now on a different diet so the food is easier to swallow.

People told us they had access to healthcare professionals when needed. One person said, "I get to see the doctor if I need them, staff are very good." Another person said, "If I get a temperature they call the doctor and tell us, communication is very good." One person shared with us a health concern the staff had identified, they said, "Staff found a lump and it all got sorted very quickly." We saw that people had received a range of support from health care professionals when required. Referrals were made when a person's needs changed and the staff required advice. For example, for two people when they were transferred it was causing concern. Both people received assessments from an occupational therapist (OT) who advised a range of different techniques and equipment. We saw the suggested equipment had been purchased and the care plan had been revised to reflect the change in techniques when supporting the person to be transferred. There had been a review and the OT had discharged them as the concerns had been resolved. This demonstrated that people's health care was considered and measures put in place to maintain people's wellbeing.

Staff told us they had received regular training. One staff member said, "I have attended training in MCA and DoLS and I am currently attending some end of life training." Other staff told us they had received training in dementia. We saw people received competency checks following training to ensure they had understood the training and were able to put it into practice. We saw when staff progressed in their role they had support and training. One staff member told us, "We do quizzes at the end of the e- learning and things are checked by the training coordinator."

When staff commenced their employment at the home they completed an induction programme and shadowed experienced staff. One staff member said, "The numbers of shifts you shadow depends on your experience or how confident you feel." We saw staff new to care had completed the national care certificate. The care certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. This meant staff received the support they required for their roles.

Good

Is the service caring?

Our findings

Staff knew them well and had established relationships with them. One person said, "Staff must be handpicked, much younger than us, but understand us, comes naturally to them, must get satisfaction seeing improvement in me." Another person said, "Care here is wonderful, staff are very friendly, have fun with them, all of the staff are lovely people."

People felt relaxed with the staff. One person said, "If any problems even personal problems you can talk to the staff, they have said to me never ever sit worrying about anything, come to us and we will sort it." Other comments included, "If there's a problem, staff always there to sort it, you can go to any of them." And, "I could speak to the staff about anything, good people, all very nice." People's facial expressions and responses indicated they were very at ease with staff. We saw how people had items that were important to them. For example, handbags, a tie, 'baby' doll. Staff understood the importance of these items. One staff member told us, "Timmy the doll is so important to [name], they change its clothes every day and it is a social aspect as other people take care of the 'baby' or talk about it."

Relatives told us they felt welcomed and relaxed at the home. One relative told us, "Staff make me welcome, coffee at the ready, really good." Another relative said, "Staff friendly, always make you welcome, always approachable and quick to respond." We saw relatives arriving at different times; staff welcomed them and ensured their relatives were comfortable. Some people were supported to their room for privacy.

People's privacy and dignity was respected. One person said, "Lovely here, honesty, this place is absolutely gorgeous, staff out of this World." Staff were observed and heard to be discreet when people needed assistance. One person said, "Staff are discreet, they say can I have a few minutes with you and make it as private as they can." On one unit we saw they had a 'dignity tree'. People's comments and thoughts had been placed on hand prints. These included having opinions and happiness thoughts.

We saw that staff reassured people who were anxious and distressed and responded promptly, calmly and sensitively. One person said, "Staff are very nice, very friendly, have a laugh and joke, help all day long." We saw staff knocked on people's bedroom doors and identified themselves on entering the room and doors were closed when personal care was being given. This showed people's dignity was respected.

Good

Is the service responsive?

Our findings

People and those important to them had been included in the development of their care plans . One person said, "Staff have a chat to see how I like things done." Another said, "They all know how I like things." A relative said they felt included in the care process, they said, "I feel staff continuity is good, we know all the staff and [name] knows them, they know their likes and dislikes." Another relative said, "Staff seek our knowledge about our family member's past life and what they enjoy."

We observed staff responding to people and having conversations about their life and acknowledging their important relationships and life events. Staff demonstrated they knew everyone's routines, likes and dislikes on dressing and food preferences. One staff member said, "Some people can't tell you what is wrong, but you can tell by little changes in their behaviours that something is not right."

When people initially moved to the home, we saw an assessment was completed. One relative said "[Name] only came here a couple of days ago for a week's respite, but the home had details from social worker's assessment, and the staff went through everything." They added, "When I telephoned yesterday staff were able to give clear feedback on our relative, everyone has been very welcoming."

The care plans contained all the information about the person; we saw they had been reviewed regularly. There was a separate file which contained charts to reflect people's individual daily requirements to record any repositioning, records of nutrition and fluids. People's rooms were personalised with items that depicted their past and present lives. The staff told us, "Each person had things which relate to them, like from their working career or hobbies."

People were encouraged to be independent and had choices about how they filled their time. One person said, "I joined in the activities this morning, playing catch, dancing and singing, old war songs, I enjoyed that. I have been on a couple of trips, we went to see aeroplanes. Always plenty going on here, lovely patio area, sit out in nice weather." Another person said, "I watch the TV and help to tidy up, it passes the time. Love the singing and dancing, have some good fun. Go out in the garden which is nice, garden lovely when the sun shines." Each unit had developed activities which were suitable to the people's needs and an activities coordinator provided some guidance and organisation for entertainers and community visits. One the day of the inspection one unit was engaged in singing and picture recognition quiz. We saw people singing spontaneously and there was a relaxed approach with people joining in as they wished. Other units had a singing group who came in and provided entertainment, which was positively received. There was a newsletter which showed residents participating in the various activities. For example, a visit from Rupert the horse, a vintage tea party, the visiting Pet Zoo, a local choir and church services. There was a varied plan of activities and people were able to access activities across the units. For example, there was a musical planned in one unit, which people from the other units would be invited to attend. One to one sessions were offered to people who did not wish to engage in the group activities. This meant people were encouraged to engage in activities of interest to them.

People felt able to raise any concerns. One person said, "No complaints that I feel I need to flag up."

A relative said, "If any concerns I would be happy to raise them." We saw that when the home had received complaints they had responded formally and in line with their policy.

Requires Improvement

Is the service well-led?

Our findings

We saw that audits had not always been consistently reviewed and used to drive improvement. On one unit the last medicine audit was completed on 21 April 2017, this had not identified any areas of concern or development. We reviewed the medicines and found several areas which should have been identified by an audit. For example, there were no rescue plans documented for people who are living with diabetes who may require support if they became unwell. The audits had also not always identified that some as required medicine (PRN) were not sufficiently detailed. For example, one person required two PRN medicines for different health conditions. The lack of appropriate description of presenting symptoms would make it difficult to distinguish between an angina attack and a panic attack. This may result in the incorrect medicine being administered; particularly if the staff may not know the person well. Other medicines had specific administration instructions to be given before food. The arrangements in place were on a verbally basis between staff who mentally noting how long to wait before offering the person breakfast. This is not a robust method of ensuring that the instructions are followed as the actual time of administration is not recorded. Some medicines were required to be halved, the staff did not have the appropriate equipment to enable the tablet to be halved and we observed staff using a kitchen knife and their hands, gloves had not been used. We saw in one medicine room the air temperature was regularly recorded as higher than the agreed guidance at which medicine should be stored. The manager told us it had been raised with the provider, however we saw no audits were it had been identified or records to show this had been shared with the provider. This meant we could not always be sure areas of concerns had been identified and rectified.

We found that systems were not always in place to ensure the consistent monitoring of each unit. We saw that each unit had a system to record the accidents and incidents which occurred. On one unit the audit for July had not been completed. Information contained within the care records identified some people had fallen. Staff were unable to find the relevant paperwork were they had recorded the fall and the audit for that month had not been updated. We saw some units used the information to reflect any concerns, however details were not reported into the larger audit completed by the manager. The information being recorded was not in enough detail to consider any trends, due to it being just figures. There was no detail relating to location or time of the incident or if it was witnessed or witnessed. We discussed the audits with the manager, they told us they planned to complete an analysis of the information to consider any trends or areas to be addressed, however this had not yet been completed.

On the day of the inspection the home was using agency staff. The registered manager told us when agency staff are used, each unit completes a site checklist and attaches that information to the staff profile. We saw that this had not happened. No check list had been completed and the profiles of the agency staff member were not available. There was a file completed on each unit which contained a photo of the person and a summary of their needs. We found the file for the people upstairs was in the office downstairs. The agency staff confirmed they had not received the checklist or had the opportunity to review the summary care plans. The registered manager told us they had started using a new agency and they had not ensured the profiles were available or that the checks had been completed for the agency staff. This had an impact on

the care which was provided. For example, people were delayed in getting up and other people had to wait for their meal at lunchtime.

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

The provider had asked for feedback from the people who use the service and their relatives. We saw that last year's questionnaires had been combined to reflect the answers provided and actions had been taken. For example, improved recruitment of staff and additional activities. The provider was currently completing the annual questionnaire and would be compiling the results and any actions. We discussed with the registered manager how they shared the outcome from the questionnaire and options they planned to consider so that people and relatives could review any action they had taken.

The manager told us they had commenced a 'walk round' of the home on a two weekly basis. This was to consider any areas of improvement and to familiarise themselves with the people and their relatives in the home. Not all the relatives we spoke with were aware who the registered manager was, however they had provided several opportunities to engage with relatives. To date there had been little response, on the day of the inspection there was a planned open day, but no relatives engaged in this event on the day. The registered manager told us they would continue to try a range of engagement opportunities.

The registered manager told us they met with the provider and any actions of these meetings had been recorded. They were unable to share with us the record of these meetings, however evidence provided after the inspection visit supported a range of meetings which had been completed to reflect improvements to the home. These included decoration and the consideration of technology to support situation when people were at risk of continued falls. This meant the provider was taking an active role in the running of the home.

People told us they found the service to be kind and friendly. One person said, "I didn't want to come in at first but wouldn't leave it for any money now, I took to it straight away, good place I would recommend it to anyone." Staff working in the home who we spoke with felt supported by the registered manager. One staff member said, "I have worked at the home for a long time, I love my job and enjoyed coming to work . The manager of the home is supportive and receptive to new ideas." Staff told us they had received support in relation to supervision from the senior person in their unit. One staff member said, " I have formalised supervision about six times a year." They added, "We meet as a team regular and there is an open door approach here."

The registered manager understood the requirements of registration with us and had ensured we had been notified of any events or incidents which had occurred at the home. The home had displayed their latest CQC inspection report in the reception area of the home. This was also published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not always in place to assess, monitor and improve the quality of care. When agency staff were used the relevant checks and inductions had not always been completed.