Horizon Care Homes Limited

Wood Hill Grange Care 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 18 September 2018 and was unannounced. The last inspection took place in November 2015, when the service was rated overall Good. You can read the report from our last inspections, by selecting the 'all reports' link for 'Wood Hill Grange Care Home' on our website at www.cqc.org.uk.

Wood Hill Grange Care Home 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.

Wood Hill Grange Care Home provides accommodation for up to 75 people. The home consists of four separate units, one providing accommodation and personal care and the other three providing nursing care. Some people receiving support at the home were living with dementia. The home is in Sheffield. At the time of our inspection there were 54 people using the service. This included some people who were staying at the home following a hospital stay but were not well enough to return home.

At the time of our inspection there was no registered manager employed at the home. 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 provider had appointed a manager who was in the process of registering with the Care Quality Commission and was employed at the home.

The registered provider had systems in place to ensure people were protected from the risks of abuse. One incident was reported to the head of care during our inspection and appropriate actions were taken when the head of care had been alerted.

Risks associated with people's care were identified. However, some risks were not always managed in a safe way.

We completed a tour of the home with the manager and found that some areas of the service were not maintained in a clean state. We brought these concerns to the attention of the manager who acted on the day of our inspection to address the issues raised.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, information regarding people's best interest decisions had not always been documented.

People received a healthy, balanced diet which met their needs and took in to consideration their preferences.

Staff received training and support to carry out their role. Staff we spoke with told us they received regular training. However, they told us that supervision sessions were not taking place regularly, but they felt supported by the management team.

We observed staff interacting with people who used the service and saw they were kind and caring. We observed staff maintaining people's privacy and dignity.

The registered provider had a system in place to monitor the service. A range of audits were in place and most of them identified areas of improvement and these were addressed in a timely manner. However, we found the audits in relation to medicine management and infection control were not effective as they had not identified the concerns we raised during our inspection.

People, their relatives and staff were asked for their view regarding the service. We spoke with the manager who informed us that feedback from questionnaires was not displayed in the home. The manager told us they would look at ways they could make this more accessible to people who used the service and their relatives.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to Regulation 12 safe care and treatment and Regulation 17 good governance. You can see what action we told the provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

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

Risks associated with people's care were identified but not always managed effectively.

Medicines were not always managed in a safe way.

We found some areas of the home were not maintained in a clean state.

There was a system in place to safeguard people from abuse.

Staff were available to meet people's needs.

Is the service effective?

Good

The service was effective.

People were given choices and staff were aware of current legislation. However, this was not always formally documented.

Staff told us they received appropriate training to carry out their responsibilities.

People received a healthy balanced diet which met their needs.

People had access to ongoing healthcare professionals as required.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their manner and approach to people.

We observed staff interacting with people and found that they respected people and maintained their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We looked at care records and found they could be more detailed and personalised.

Staff understood how to meet people's needs at the end of their life. However, some details within care plans were not always clear.

Complaints were dealt with appropriately and used to improve the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered provider had systems in place to monitor the service. However, audits had not highlighted the issues we raised on inspection.

People, their relatives and staff were asked for their view regarding the service. However, the outcome was not always fed back to people.

Wood Hill Grange Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 18 September 2018 and was unannounced. The inspection was carried out by three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We did not ask the registered provider to submit a provider information return [PIR] for this inspection. 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 also spoke with other professionals supporting people at the service, to gain further information about the service.

We spoke with 15 people who used the service and 7 relatives of people living at the home. We spent time observing staff interacting with people.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 17 staff including care workers, senior care workers, nurses, catering staff, activity co-ordinator, the manager, and other members of the senior management team. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at people's care and support records, including the plans of their care. We saw the systems used to manage people's

medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's care had been identified. However, actions to manage the risks were not always in place to ensure people's safety. We identified that moving and handling risk assessments did not contain all the required information to ensure people were moved safely. For example, three people's risk assessments detailed the type of sling and that two members of staff were required to assist, but did not state the loop configuration to use. We observed one of these people moved by staff. On each occasion a different loop configuration was used. On the first occasion we saw the yellow loops were used and on the second occasion we saw the blue loops used. On the second occasion the person was too close to the stand aid, which caused their clothes to ride up their back. They were also unable to weight bear correctly to ensure they were safe to use the stand aid. This was an unsafe moving and handling procedure and staff did not have the correct information in the risk assessment to ensure correct loop configuration and people's safety.

We also identified people's risk assessments in relation to tissue viability were not always followed. For example, one person's care plan we looked at had identified them to be at risk of pressure ulcers and that they required a position change every four hours. The records completed showed at times there were nine hours between position changes. On one entry it recorded that the person was placed on their left side at 22.00 hours and then at 00.04 and 04.00 hours the person was asleep and were not moved to change position until 07.00. This did not manage the risk as indicated in the risk assessment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks associated with people's care were not effectively managed to keep people safe.

People had a personal emergency evacuation plan (PEEP) to ensure people were appropriately supported in an emergency. Staff and people were regularly involved in fire drills. The PEEP set out specific physical and communication requirements that each person required to ensure that they could be safely evacuated from the service in the event of an emergency.

We looked at systems in place for managing medicines. This included the storage, handling and stock of medicines and medication administration records (MAR's) in place for people. Medication was stored in clinical rooms on each floor as well as in people's bedrooms. The temperatures were monitored and it had been found that the temperatures were regularly above the recommended 25 degrees centigrade. We discussed this with the head of care who told us they had identified this and were going to cease using bedrooms to store medicines, as the temperatures were too high. At times they had been above 30 degrees centigrade. However, this did not address the high temperatures in the clinical rooms. Fans had been used and windows opened but temperatures were still recording above the recommended temperature. The head of care assured us this would be monitored and would consider acquiring air conditioning units.

We found on one unit the refrigerator was stored in a small cupboard, which was very warm and was full of medication. We were told the medication was all to be returned but the staff member did not have a record of the medicines. We found there was no returns book completed so it was not possible to audit medication

effectively and safely. On the same unit, the controlled medication was also kept in a cupboard where the temperature was not checked daily. We saw it had been recorded on the 4, 8 and 12 September 2018 and on each occasion, it was above the recommended temperature.

We observed staff administering medicines to people and saw that predominantly safe practices were followed and staff took time to explain to people what the medicine was for. However, we identified that a time specific medicine had not been administered on two occasions. The persons relative brought this to our attention as the medication needed to be given every two hours and had not been given twice on the morning of our inspection. The relative told us, "I can see [my relative] hasn't had the medication in how [relative] is presenting. It had a detrimental effect when [relative] doesn't have them in time." The staff member on duty who was responsible for administering the medication was an agency worker and had not worked at the service for over four months so did not know the person. They told us, "I was not told at handover the person was in the home so was not aware of the time specific medication."

We looked at this person's care plan and they had been admitted from hospital on 13 September 2018, five days prior to our inspection. We found limited information in the care plan. The care plan for their medical condition did state the person had a strict regime of medication, but there was no other information to guide staff on how to manage this and meet their needs.
During our inspection the provider began to take action to address the concerns we raised with them.

Some people were prescribed medication to be taken on an as and when required basis, known as PRN medicine. We saw some protocols were in place and gave detail to guide staff on when to administer the medicine. However, we found some protocols were not followed. For example, one person was prescribed pain relief to be given when required. However, the MAR was highlighted to indicate that this should be administered four times a day and was being given as a regular dose.

We also found that when PRN medication was given there was a lack of detail on the MAR to explain why it had been given and no evidence or review to ensure it was effective. For example, one person was prescribed a medication to alleviate agitation and anxiety and this medicine could cause drowsiness, but it had been given regularly and the reason was stated that the person was, 'vocal.' We noted the person was vocal throughout the inspection and staff told us the person was vocal most of the time. Therefore, is was not clear if the staff were assessing the person to ensure they were receiving the appropriate medication.

We also found some people who were prescribed PRN medication did not have protocols in place. For example, one person who was prescribed paracetamol for pain relief and lorazepam to alleviate anxiety and agitation, had a protocol for lorazepam but not for paracetamol. Therefore, there were no instructions for staff to follow to guide them on which to administer first.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of medicines was not always effective.

We spoke with people who used the service and their relatives and they told us they felt safe living at the home. One person said, "I feel secure here." Another person said, "Oh yes, I am safe here." Another person said, "I am not sure who the manager is, but there is a team leader up here [on the unit], I find them easy to talk to and could go to them if I had any worries."

The registered provider had a system in place to safeguard people from the risk of abuse. Staff we spoke with told us they received training in safeguarding. Staff were knowledgeable about how to recognise and report abuse and would action any concerns without delay. During our inspection a relative raised a

concern with the nurse on duty and with an inspector. This was reported as a safeguarding concern by the registered provider.

We observed staff interacting with people who used the service and found there were enough staff available to meet people's needs. We saw staff responded in a timely manner when people requested their support. People who used the service said, "Staff get very busy at times, but they keep us all safe," and "If you call for help they [staff]can be a long time coming." One relative said, "There seems to be enough staff. It gets a bit busy at the weekends, staff are just rushing around."

We spoke with the manager who informed us that the service had a dependency tool in place to identify the amount of staff required to meet people's needs. The manager also told us that if more staff were required then this would be provided to meet people's needs.

Predominantly this service was clean. However, some areas were not well maintained and were therefore unable to be effectively cleaned. For example, we saw worn microwaves, broken fridge seals, worn kitchenette units and inappropriate items stored in the hand basins in sluice areas Following our inspection, the registered provider confirmed that attention to these areas had taken place, for example the microwaves and fridges had been replaced.

The registered provider had a recruitment policy which assisted them in the safe recruitment of staff. This included obtaining pre-employment checks prior to people commencing employment. These included references from previous employers, and a satisfactory Disclosure and Baring Check (DBS). The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. We looked at three staff recruitment files and found they contained the relevant checks.

The registered provider completed regular checks to ensure nursing staff employed at the service maintained their professional status and pin numbers.

Good

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and found that people received support from a staff team who were trained to carry out their role and knew their responsibilities.

The registered provider ensured that training took place regularly and staff told us they valued the training they received. Training was completed via eLearning and face to face training sessions led by the registered provider's trainer. In addition to training supplied, staff also had competency checks to ensure they had the knowledge to carry out roles such as medicine management.

Staff told us they felt supported by the management team although some staff told us they had not received formal supervision sessions. Supervision sessions were one to one meetings with their line manager. These gave staff the opportunity to discuss work related issues. Although staff told us they did not receive regular supervision, they felt able to speak with members of the management team and found them supportive. One care worker said, "I am not receiving regular supervision or appraisal. It is overdue. There are always people to talk to if you have a problem."

Following our inspection, we were sent a supervision matrix which showed that supervision had taken place and when the next session was scheduled.

Human resources surgeries took place so that staff could discuss work related issues with the management team. Staff informed us that they had the opportunity of accessing one of these sessions the day prior to our inspection and felt they were useful.

The service had an effective induction process which incorporated training and shadowing experienced staff. Staff we spoke with felt supported through their induction and felt it gave them knowledge to get to know people and what their needs were. The management team told us that all new staff employed would be registered to complete the 'Care Certificate' which replaced the 'Common Induction Standards' in April 2015. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act required that, as far as possible, people make their own decisions and are helped 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 people lack mental capacity to take 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of

their liberty were being met.

We looked at documentation and found that DoLS had been submitted, some had been approved and others were awaiting assessment. The care plans detailed where people were in the assessment process. We saw where people lacked capacity staff had considered best interests. We saw some best interest decisions contained good detail and involved all relevant people to assist with making decisions in the person's best interest. However, best interest decisions had not always been documented. For example, one person had bed rails in place and there was a risk assessment but no best interest decision. Staff told us this person was living with dementia so lacked capacity to understand why the bed rails were in place. Another person was not taking their medication, staff told us they were spitting it out. The GP had discussed covert medication with staff, but this had not been followed up. Staff had not completed a best interest decision to determine that it was in their best interests to administer the medication covertly and the person was still refusing to take their medication. Following our inspection, the registered provider sent us assurances that best interest decisions were now documented.

People received a healthy, balanced diet which met their needs. We spoke with catering staff who were aware of people's likes and dislikes. Catering staff were also knowledgeable about people's diets and any individual requirements were catered for.

The catering system was predominantly delivered through a range of ready-prepared meals from a specialist provider. We saw there were a range of 'specialist diet meals' available. The home also prepared some aspects of meals and snacks at the home. This allowed the catering team to provide meals that were low in fat and sugar for diabetics, energy dense for people declared to be underweight and meals that were free from allergens. Everyone we spoke with were complimentary about the food and choices available. Comments included, "I like the food here and there's plenty of it," and "The menu is really varied," and "All the menus are on display. We can always see what we are having for our meals."

The catering team could demonstrate that people had a choice of meals. People were asked to select choices from the menu prior to meals so that options could be prepared.

We observed staff who were very calm and patient when serving meals. People were offered a choice of food for lunch and their preferences and choices were respected. One person had requested 'a bit of soup' and said, "I only want a very small sandwich." We saw this was respected. Two people changed their minds once they had started their sandwiches, but this was exchanged by the staff in a very polite and courteous manner.

One care worker said, "I understand the importance of promoting people's well-being through good nutrition."

People had access to healthcare professionals as required. People and their relatives told us staff supported their family members to access healthcare professionals so they could remain as well as possible. People described visits from community nurses and GPs, and plans were agreed so that people's needs could be met.

One person said, "They [staff] make all the arrangements for me to see my doctors." Another person said, "I see the district nurse regularly, they [staff] make sure of that." One relative said, "They always keep us informed about any medical appointments."

We spoke with visiting healthcare professionals and were told that staff worked with them well and

communicated any changing needs as appropriate. One healthcare professional said, "They [staff] follow specific instructions and I have excellent communication with the service." Another visiting healthcare professional said, "They [staff] are very on the ball here. There is a nurse who always helps facilitate our sessions."

Good

Is the service caring?

Our findings

During our inspection we spent time talking with people who used the service and their relatives.

People told us they liked the staff that cared and supported them. Comments included, "I feel settled and happy here," "I have improved so much since I came to live here," "I am glad I chose to live here," and "Without exception all the staff are kind to me."

We saw people were comfortable in the presence of the staff team and friendly, appropriate banter was exchanged. When one person was seen to be upset a care worker sat down beside them and reassured them. The care worker had a brief conversation about the person's bedroom and reassured the person that they had somewhere to sleep. This made the person smile and lightened their mood.

Another person was singing in the corridor and after a short while was joined by a care worker who started to sing along. The person and care worker both started laughing as they were amused by the care workers singing voice. This showed staff responded to people in a positive way.

People told us how they were encouraged to maintain their independence. Some people chose not to join in the activities and some people chose to spend time in their rooms/lounges and this was respected.

Staff we spoke with talked about practical ways in which they maintained people's privacy and dignity. These included knocking on doors before entering and helping people to do as much as possible during personal care. We observed staff knocking on doors or calling out before they entered their bedrooms. The registered provider had dignity champions who promoted dignity throughout the service and ensured people maintained their independence where possible.

Meeting people's religious and cultural needs was part of everyday practice in the home. Staff recognised that different religions had certain customs that need to be respected. Staff were knowledgeable about these and ensured people were supported.

People were supported to maintain relationships with family members as they wished and were welcomed by staff in a friendly manner. One relative said, "All of the staff are very approachable." Another relative said, "The staff are so welcoming."

People were supported to express their views and be actively involved in making decisions about their care. There was a key worker system in place where people were allocated a care worker to ensure their needs and wishes were being met and to liaise with family members.

Requires Improvement

Is the service responsive?

Our findings

We looked at care records and found they could be more detailed and person centred. For example, one person's care plan identified that they required a hoist with a medium sized sling to assist the person to mobilise. However, the care plan lacked detail regarding loop configuration. We spoke with the senior care worker who was knowledgeable about the position of the loops and confirmed that this information was passed on verbally to agency staff. Another person had a care plan in place regarding being at risk of poor nutritional intake. However, this did not give sufficient details of how to enrich the person's diet.

We spoke with people and their relatives and they told they liked the staff that cared for them. People and their relatives, we spoke with told us staff discussed the types of support and assistance they wanted before they moved into the home. A relative described how they had been consulted about how their relative preferred to be supported. One person said, "The staff know what they are doing and they care for me so well.

We also found people who were admitted for respite care, did not always have a full care plan in place. For example, one person who was admitted five days prior to our inspection had their needs identified, but there were no plans in place to guide staff on how to meet their needs. They had been identified as having poor mobility and needing assistance but the plan lacked detail on how to assist the person with their mobility to ensure their safety.

We completed a tour of the home and found there were en-suite accessible showers in all bedrooms. However, we identified that accessible baths were not available on every unit for people with limited mobility. Feedback from some people evidenced they would like a bath but did not get one.
Three people we spoke with said that they could not have a traditional bath. One person said, "It would be lovely to have a soak every now and then." Another person said, "I am not keen on the shower. I don't like it on the back if my neck but a bath would be nice."

We saw the service completed handovers at the start of each shift to ensure staff were kept up to date. Communication books were also used to ensure scheduled appointments and GP visits were requested and took place as required. However, an error with medication highlighted lack of communication at the hand over on the day of our visit.

We spoke with people and their relatives and they told they liked the staff that cared for them. People and their relatives, we spoke with told us staff discussed the types of support and assistance they wanted before they moved into the home. A relative described how they had been consulted about how their relative preferred to be supported. One person said, "The staff know what they are doing and they care for me so well."

Staff understood how to meet people's needs at the end of their life. People being cared for at the end of their lives were kept comfortable and supported sensitively. Care plans included information about people's wishes and preferences. However, we found some lacked detail. For example, one person's religious needs

had been identified, but did not give specific information for staff to be able to follow their wishes.

People were supported to take part in social activities which were socially and culturally relevant and appropriate to them. The registered provider employed an activity co-ordinator who was responsible for ensuring social needs were met in line with people's preferences. We spoke with the activity co-ordinator who said, "I am pleased that the organisation offers me training about my work. I have done training in relation to the benefits of physical exercise and I have also done the PAC (Positive Approach to Care) training. This has been so useful as I am so much more aware of the difficulties people have who live with dementia. I do all I can to access what activities are most beneficial for individuals."

Without exception, people said that they took part in, and enjoyed, a wide range of activities and outings. On the day of the inspection people were enjoying a pre-organised one-to-one session and during the afternoon a group game of bingo. Everyone who joined the bingo session was seen to be laughing and smiling and really enjoyed winning their prizes. Relatives also joined in this event. One person said, "We have such a laugh when its bingo." Another person said, "It's great when the entertainers come in. I love to dance with the singer."

The service ensured people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People's communication needs were assessed during their pre- admission assessment process and plans put in place to ensure staff could communicate with them as effectively as possible.

The registered provider had a system in place to ensure complaints were dealt with appropriately and used to improve the service. People and their relatives knew how to complain and they told us they would inform the management team if they were unhappy with their care. One person said, "I can talk to the staff about any problems I have." Another person said, "If I had a problem I would go straight to the manager.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager employed at the home. 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 provider had appointed a manager who was in the process of registering with the Care Quality Commission and was employed at the home.

The registered provider had a system in place to monitor the service. A range of audits were in place and most of them identified areas of improvement and these were addressed in a timely manner. However, we found the audits in relation to medicine management and infection control were not effective as they had not identified the concerns we raised during our inspection. For example, the infection prevention and control audit tool which was completed in August 2018, had not identified the environmental issues we raised as part of the inspection. These were in relation to worn microwaves, broken fridge seals, worn kitchenette units and inappropriate items stored in the hand basins in sluice areas and uneven flooring. Following our inspection, the registered provider confirmed that attention to these areas had taken place, for example the microwaves and fridges had been replaced.

The medication audit completed in September 2018 for all four units had not identified the issues we identified as part of our inspection. For example, the concerns around PRN protocols and recording of these and medication store rooms were being kept to the recommended temperatures, were not highlighted as part of this audit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audit systems in place were not effective.

The registered provider showed us an electronic monitoring system which was used to action issues that were brought to their attention. For example, the safeguarding concern identified as part of the inspection was entered on to this system. This evidenced that the concern had been reported to the appropriate professionals.

The registered provider had an overarching action plan which was maintained by the management team and updated as required. Following our inspection, the registered provider sent us a copy of this action plan. Issues we identified as part of our inspection had been incorporated as part of the plan.

People, their relatives and staff were asked for their view regarding the service. There was a range of quality assurance methods in place and people and their relatives were pleased to have been involved in meetings. Relatives said that they had approached the management team about various matters and they felt as though they were listened to. One person said, "I have been invited to meetings and I am happy with everything." Another person said, "The management are always asking us if we want anything to change." One relative said, "Whenever I have a question there is always somebody available to answer it. I tend to

approach the team leaders rather than the management."

Some people who use the service did not know the name of the manager but had confidence in the people that supported them.

The manager also conducted managers surgeries where people could identify a time to speak privately with the manager. The manager also informed us that they operated an open-door system where people were welcome to discuss issues as they arose.

The registered provider operated an 'employee special mention' scheme. People, relatives and staff were invited to complete an employee special mention slip, to comment on staff who were involved in their care and for colleagues. Some comments included, '[Name] always has a smile on their face,' Thanks for showing extra care to [relative],' and '[Name] is a brilliant worker.'

Staff we spoke with felt supported by the management team and felt the manager was approachable and very supportive.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not always effective. Risks associated with people's care were not effectively managed to keep people safe.

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 Audit systems in place were not effective.