MAPS Properties Limited

The Limes

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

This inspection took place on 13 and 14 June 2016 and was unannounced.

The Limes provides accommodation and support to a maximum of 46 older people some of whom may be living with dementia. It does not provide nursing care. At the time of our inspection there were 41 people living in the home.

We last inspected this service on 04 and 06 November 2014 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider was in breach of the Regulation 13 which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not managed safely. The provider was also in breach of Regulation 22 and Regulation 10 which corresponds with Regulation 18 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient numbers of staff to meet people's needs and there was insufficient quality monitoring occurring in the service.

At this inspection in June 2016, we found a continued breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found additional breaches of Regulation 12 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Improvements regarding the management of medicines had been made people had received their oral medicines as prescribed and they were safely stored.

People were not protected from avoidable harm and abuse because staff did not always identify when safeguarding referrals were required and systems did not operate effectively to ensure these were reported. Not all risks to people were adequately identified or managed, this included risks relating to the management of the premises.

There was not always enough stimulation and activities for people and there was mixed feedback regarding whether staffing levels were sufficient to meet people's needs. We have recommended the service review their staffing levels against people's individual needs to ensure there are sufficient staff.

Staff sought people's consent to their care. We have made a recommendation that the service continues to make improvements regarding mental capacity assessments and best interests decisions.

People's preferences and needs around meals were accommodated and people were supported to eat and drink enough. Staff ensured people received support from health care professionals in a timely manner.

People were supported by kind and caring staff, who ensured people were treated respectfully and with dignity. People felt involved and able to make decisions regarding their care.

People's care plans were not always detailed enough and did not contain information that was specific to them. Not everyone had been given the opportunity to review and discuss their care plans. People felt able to raise concerns and concerns were investigated and responded to.

Improvement had been made regarding quality monitoring systems; however these had been ineffective at identifying some areas for improvement. Actions had not always been taken to make sufficient improvement in some areas.

The registered manager was approachable and ensured they listened and consulted people, relatives, and staff on how the service was run. Staff understood their responsibilities and took accountability for the role. The registered manager addressed poor performance and staff told us the registered manager had improved the standard of care provided.

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.

Safeguarding incidents were not always appropriately identified and reported to the relevant authorities.

Not all risks to people, including risks associated with the premises, were adequately identified or managed.

People received their oral medicines as prescribed and these were stored safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought people's consent. Applications for DoLS had been made appropriately. We have recommended the home continue to make improvements in their practice regarding the requirements of the MCA.

People were supported to eat and drink enough and receive the health care they needed.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff, who promoted their dignity.

People felt listened to and their views regarding their care were taken in to account.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always opportunities for people to discuss their care, however people felt able to raise concerns and action was taken to address these.

People were not always provided with enough stimulation and activities.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring was ineffective, this had resulted in a lack of identification of areas for improvement and sufficient improvement had not been made in some areas.

There was an open and inclusive culture, people and staff felt listened to and involved in decisions about the running of the service.

The registered manager ensured people understood their role and responsibilities.

The Limes

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 June 2016 and was unannounced. The inspection was carried out by one inspector. We did not request a Provider Information Return (PIR) form from the provider before this inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also contacted the local safeguarding team, quality assurance team, and health commissioners for their views on the service.

During our inspection we spoke with nine people using the service and three visiting relatives. We spoke with nine members of staff. This included the registered manager, deputy manager, care coordinator, a senior carer, three care assistants, the activities coordinator and the cook.

Not everyone living in the Limes was able to speak with us and tell us about their experiences of living in the home. We therefore observed how care and support was provided to people and how people were supported to eat their lunch time meals.

We looked at five people's care records, three staff recruitment files and staff training records. We checked the medicines records for four people. We also looked at quality monitoring documents, accident and incident records, compliments and complaints records, and minutes of staff and residents meetings.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm. We identified several incidents during our inspection that had not been identified as improper treatment and were not referred to the local authority safeguarding team when required. This meant the local authority had been unable to take action and provide support. One of these incidents involved a person with behaviour that might challenge others. When we discussed these types of incidents with the registered manager and staff there were differences in understanding about how these should be recorded and reported. We discussed this with the registered manager who took immediate action to report these incidents to the appropriate authorities. This demonstrated that the current systems and knowledge were not effective enough to ensure safeguarding concerns were reported as required.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people we spoke with felt safe living in the home, however two of the people we spoke with raised concerns regarding other people coming in to their rooms during the day and night.
One said, "I sleep with one eye open." They went on to tell us about an incident when someone had come in to their room at night which had resulted in them suffering harm. We saw two people were concerned about items going missing from their rooms. One person said they were reluctant to leave their bedroom because of this. Records showed a family member of another person had raised concerns regarding missing items. Although this issue had been raised at a resident's meeting insufficient action had been taken to resolve the situation and minimise the risks relating to this for people living in the home.

Risks to people had not always been identified and responded to appropriately. Medicines for external administration were left out in people's rooms this left people at risk of accidental harm. We saw one person's food intake had been monitored for three days when first admitted to the home. The records showed that the person had eaten very little in the first three days and had lost 2.7 kilograms in the first week. No subsequent action had been taken in response to this. There was no risk assessment in place and food monitoring charts were not continued or reinstated. There was no record that health professionals had been consulted regarding the person's weight loss. Another person had been identified as being at high risk of skin breakdown; however there was no specific care plan or risk assessment in place to address this. We saw two other care records had risk assessments that had not been completed, regularly reviewed as required, and contained inaccurate information.

One of the records we looked at showed a person was at risk of choking. A speech and language therapist had advised that in order to mitigate this risk they required food to be prepared and given to them in a way that made it easier for them to swallow. Records indicated this was not always followed and on two occasions staff gave the person food in a form that placed them at risk of choking.

We saw a number of people were at risk from malnutrition and in order to manage this risk required their weight to be monitored on a weekly basis. Records showed that people living in two of the units had not had

their weight monitored for a month and people living in the third unit had not been weighed for two weeks. The registered manager told us this was because their weighing scales had been broken and they were waiting for a replacement. We queried how this risk was being managed. The registered manager told us that staff were ensuring people had assistance when they needed it at meal times and staff monitored what people ate. However, there were no records, such as food charts, being kept regarding these people's food intake. This meant it would be difficult for staff to assess, review, and evaluate if people at nutritional risk were eating enough. We were concerned given the length of time people had not been weighed that these measures were not robust enough to adequately manage this risk.

Some risks to people regarding the premises were not adequately managed or risk assessed. For example, required checks on fire safety such as emergency lighting and fire extinguishers had not been carried out. There were also no records to show that risk assessments or regular tests regarding legionella bacteria had been carried out. Other routine maintenance such as portable appliance testing and servicing of the lift had been carried out.

The above information meant that not all risks were regularly reviewed, managed or reduced. It also meant that new or agency staff did not have up to date guidance in the event that permanent staff were not available. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection on November 2014 identified a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 this corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified a breach in the regulations because there were not sufficient staff to meet people's needs. At this inspection we found that improvements had been made and the service was no longer in breach of this regulation.

We received varied feedback from people and relatives regarding staffing levels. One person told us shifts were sometimes short of staff. They told us at night time they sometimes had to wait twenty minutes for a member of staff to respond when they rang for assistance. A relative told us they felt more staff were required and they were aware on occasions shifts ran short of staff. They told us they had visited recently and spent fifteen to twenty minutes trying to find a staff member to provide their relative with assistance. All the staff we spoke with told us there could be issues with staff giving short notice that they were unable to work, they told us that the registered manager used agency staff to ensure shifts were fully covered.

The registered manager told us they used a tool to help them assess how many staff were required to meet people's needs. The dependency tool helped them identify what needs each person had and how many staff were required to support them. However, these tools were kept on each person's care record and not together. This meant it was difficult for the registered manager to analyse people's needs overall in the home and there was no evidence of an overall analysis of people's needs in relation to staffing numbers. The registered manager told us they worked on a ratio of five people to one member of care staff and staffing numbers demonstrated this was the case. However, this ratio did not take in to account people's varying dependency levels and individual needs. On the day of our inspection we saw there were sufficient numbers of staff. We recommend that the service review their staffing levels against people's individual needs to ensure there are sufficient staff.

Staff files showed safe recruitment practices were being followed. This included the required health and character checks, such as references and Disclosure and Barring Service (DBS) checks, to ensure the risk of employing unsuitable staff was minimised as far as possible.
Our previous inspection on November 2014 identified a breach of Regulation 13 HSCA 2008 (Regulated

Activities) Regulations 2010 this corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified a breach in the regulations because medicines were not stored securely, the competency of staff administering medicines was not always checked and staff did not always know what medicines were stored on the premises. At this inspection we found that improvements had been made and the service was no longer in breach of this regulation.

At this inspection we found improvements regarding the management of medicines had been made. We looked at four people's medicine administration records. These showed oral medicines were administered as prescribed and were stored securely. The temperature at which medicines were stored was checked regularly so that staff could be sure medicines remained effective to use. We checked three medicines and saw the stock count was accurate. The registered manager told us staff competency was now checked on a regular basis and staff we spoke with confirmed this. We saw that the service had put in place weekly medication audits which helped ensure medicines were being administered correctly.

One of the medicine administration records we checked did not have available written information to show staff how and when to administer as required medication. However, we saw this was in place for other people who needed as required medication.

Requires Improvement

Is the service effective?

Our findings

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.

We saw mental capacity assessments and best interests decisions were documented and in place regarding some decisions. For example, we saw one person's ability to make decisions regarding their diet had been assessed and another person's capacity had been assessed in regards to their mobility and fluid intake. However, records showed that people did not always have assessments of capacity in place where required. For example, we saw that two people's care records stated they did not have capacity to administer their medicines but no mental capacity assessment was in place to evidence how this had been assessed. This meant the MCA was not being followed consistently. We recommend that the service continue to make improvements in this area.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 a person of their liberty was being met.

We saw the registered manager had made DoLS applications which were appropriate and they demonstrated they were aware of their responsibilities under this legislation.

The staff we spoke with had variable knowledge regarding MCA and DoLS. However, they demonstrated that they understood the importance of consent, offering choice, and helping people to make decisions. During our inspection we witnessed this in practice as we saw staff checked people's consent to the care they were providing. One person told us staff always ensured they knew what staff were doing and said, "I've never done anything I don't want to."

People and relatives we spoke with told us they felt staff had sufficient skills and knowledge to meet people's needs. One relative gave us examples that showed staff were skilled at managing certain aspects of their relative's behaviour.

Most of the staff we spoke with talked positively of the training and support provided and felt this supported them to provide effective care. A member of staff told us, "Training gives us the support to handle incidents." However, one member of staff felt that there was too much eLearning and they found this did always suit their style of learning.

Training records showed most staff received training that was relevant to their role. However, care assistants

were required to write people's care plans and had not received any formal training in regards to this. One member of staff said they struggled with writing care plans. Other staff told us they had received informal support from the deputy manager and care co-ordinator to help them carry out this task. We saw some staff required refresher training and this was overdue; however the registered manager had identified this and had a plan in place to address this.

New staff were supported by an induction, several staff told us the induction has been helpful and had included observations of their practice to ensure they were ready to work in the home. One member of staff told us they had, "Learnt a lot" through their induction.

All the staff we spoke with said they received regular supervisions. Staff we spoke with felt supported to provide effective care by the registered manager and their colleagues. Several staff told us the registered manager was approachable and there was a team approach to problems. Another member of staff told us a lot of staff were very experienced and this meant there were plenty of people they could go to for advice and support.

People were supported to eat and drink enough. A relative told us how staff had really encouraged their relative to eat and as a result had they had put on weight. The relative told us this was a big achievement. People told us their personal preferences were catered for. We observed one person was not keen on the meal options provided on the day of our inspection and staff discussed with them what they would prefer, which was then provided.

We observed the support provided to people over lunch and saw where required each person had one to one support to assist them to eat and drink. We observed people enjoying their food. However, one person who chose to eat in their room told us they had not enjoyed their lunch time meal as staff had forgotten to bring them cutlery and they had had to wait twenty minutes for cutlery to be provided. They told us by this point their lunch was no longer warm and it was not reheated.

Records we looked at showed where required referrals had been made to health care specialists so that people were supported to eat and drink. For example we saw staff had identified concerns around people having difficulty eating and had requested specialist assessments so they knew how to help the person.

People were also supported with other health care needs. These included ensuring referrals such as for nursing support or specialist mental health support were made. We saw concerns regarding people's health care needs were acted on in a timely manner.

Good

Is the service caring?

Our findings

People living in the home and their relative's spoke highly of the home and the support provided by staff. One person told us, "Staff do the best for you." Another person told us staff were kind and friendly, they said staff will, "Have a chat if you want." A relative told us staff put the people living in the home first and another relative said staff were very patient and, "Lovely."

Positive and caring relationships had been developed between staff and people living in the home. Two relatives gave us examples that demonstrated staff were thoughtful and cared about the person's happiness. Another relative told us how their relative had developed really strong relationships with several members of staff and how fond they were of each other. One person said, "[staff] make me as comfy as possible." We observed that staff reacted quickly to comfort and reassure them when distressed. For example, we saw one person had become distressed and a member of staff sat next to the person holding their hand and offering reassurance.

People and relatives told us they felt staff knew them well. One person told us how staff knew their favourite sweets and on one occasion had gone out to buy some for them. One relative said, "They have knowledge of [name] as a person." The staff we spoke with demonstrated they knew the people they were caring for and their likes and dislikes. They spoke respectfully and with fondness regarding people in the home. One member of staff said, "I treat people they way I would want my family to be treated" and another staff member told us, "It's more than just a job."

The registered manager had introduced communication books in people's rooms to ensure people and their families could raise issues regarding their care. People and relatives told us they felt listened to and their views regarding their care needs were sought. One person told us, "If you ask they'll [staff] sort it out." We observed this happening in practice, as staff always sought people's opinion on their care. For example, asking people if they wanted to wear a clothes protector at meal times.

Relatives were free to visit when they wanted and we observed relatives visiting throughout the day. Relatives were welcomed and put at ease by staff. We observed staff greeted relatives warmly and offered them drinks. One relative told us how kind staff had been to them and offered a lot of reassurance when their relative first came to live in the home.

People told us staff treated them respectfully and with dignity and we observed this to be the case during our inspection. One person said staff were "Very polite" and always knocked on their door before they came in their room. Staff were able to tell us about practical things they did which respected people's dignity and promoted people's independence.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us the service provided personalised care that was individual to their needs. One person told us "You can do anything you like" another person told us how staff respected and supported their preferred daily routine. A relative told us how care was provided in an individualised way they said, "[Staff] are catering for [name]."

We looked at four care plans and we saw that whilst some people's personal preferences were documented, the care plans did not always contain sufficient information. For example, one person's mobility care plan stated the person's mobility had deteriorated but did not state in what way. Care plans were not always individual to people's needs. For example there was no information in place about how to support people with diabetes or behaviour that could be challenging. This meant staff did not have sufficient written guidance to meet people's needs. It also meant that new or agency staff did not have sufficient guidance to meet people's needs in the event that permanent staff were not available.

Some care records contained contradictory information. For example one person's care record contained information that their behaviour could be challenging at times. We saw there was no mention of this in their care plans. Another person's risk assessment said they required a food and fluid chart as well as fortified food. Their care plan did not contain this information and the deputy manager told us food charts were not completed.

The registered manager told us care plans should be reviewed and updated monthly, however the records we looked at showed this was not always happening. For example, we saw one person had been prescribed additional supplements on 20 April 2016 in order to manage nutritional risks. The doctor had visited again on the 4 May 2016 and requested their weight be monitored. Their care plan regarding nutrition was dated 15 April 2016 had not been reviewed and updated to show this additional information. Another person's care plan written in 8 March 2016 regarding their mental health showed they could display behaviour that challenged themselves and others. A letter from their mental health professional dated 6 June 2016 showed this was no longer a significant care need and improvements in the person's mental health had been made. Their care plan had not been reviewed since written on 8 March 2016 and had not been updated to show this information. This meant care plans did not contain up to date information.

People's needs were assessed prior to coming to live in the home. However the written pre-admission assessment of people's needs was not always detailed enough. We saw one person's pre-admission assessment regarding their physical and mental health needs had not been completed. They had been living in the home for six weeks; however no care plans regarding how to meet the person's care needs had been completed. This meant staff did not have guidance about how to meet the person's needs the way the person wanted.

In three out of the four care plans we looked at there was a lack of information regarding people's personal history, interests, likes and dislikes. Providing this information to staff can help them understand the people they are caring for in greater depth and helps ensure people have care provided in a way that takes into

account their individual needs.

People and relatives we spoke with told us there were no formal opportunities to discuss and review their care needs. Three out of the four care plans we looked at had no evidence people had been involved in the planning and reviewing of their care. This meant care plans were not person-centred and did not reflect how the person wanted to be supported.

The registered manager acknowledged this needed to improve and had implemented a new system. We saw that this had been put in place with one person. Their records showed they had asked for their care plan to be discussed with their relative and they had been asked how often they would like to formally review their care plan.

People, relatives, and staff felt activities in the home could be improved. One person told us they would like more activities and more opportunities to play board games. A relative told us their relative had a sensory impairment and often the activities organised were of a nature that meant their relative could not join in. They told us they visited the home often and didn't see many activities on offer. Three of the staff we spoke with felt there were not enough activities for people. Two staff felt two activities co-ordinators would be better as there were a lot of people living in the home and two separate lounges. Staff told us there were no planned trips out of the home. This meant some people had little opportunity to get out of the home or participate in their local community.

On the day of our inspection we saw that the activities co-ordinator offered activity options to people and we saw they encouraged a number of people in the lounge to participate in painting or drawing. We saw a number of people required one to one support in order to participate fully in these activities, we observed the activities co-coordinator tried hard to provide this by sitting in between people as well as talking and encouraging people sitting further away.

People and relatives told us they felt able to raise concerns and knew how to do this. One person told us, "I take my complaints to [registered manager] and they sort them out." A relative said the registered manager was 'very approachable" and took action to address any concerns they raised.

We saw the complaints procedure was on display at the entrance of the home. There was also a compliments and complaints book available in the entrance hall. This enabled people and visitors to raise concerns if needed. We saw that complaints had been investigated and responded to by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection in November 2014 identified a breach of Regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2010 this corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified a breach in the regulations because the service was not checking the quality of the service provided and regular auditing and monitoring was not taking place. At this inspection, we found that some improvements had been made but that the provider remained in breach of this regulation.

The registered manager had implemented a number of quality audits and checks. These included weekly medication audits and health and safety audits. We saw the registered manager completed a monthly update on the service which required them to audit a wide range of areas such as complaints, accidents and incidents, people at risk of skin breakdown, people at nutritional risk, staff training, and staff supervisions. They also carried out monthly observations of staff's practice on both the day and night shifts. Where issues had been identified we saw the registered manager had written an action plan and updated this on a monthly basis. Whilst quality monitoring had improved, the systems in place had not been sufficient to identify or address some of the issues we identified during our inspection.

During this inspection we identified that there were continuing concerns regarding how people's medicines were managed and in regards to staffing levels. These areas had not been sufficiently improved since our last inspection on the home.

Care plans did not contain sufficient, accurate, and up to date information regarding people's needs. This meant staff did not have the correct guidance. This was of particular concern as some of the staff working in the home were agency staff. Whilst we saw senior staff were auditing care plans this was ineffective. We saw in some cases issues with gaps in information had been identified however these were not followed up. For example gaps in information on one person's care record had been identified at the beginning of March 2016 however at the time of our inspection, three months later, the record had not been completed.

Medicine administration records were not always complete. We checked four people's medicine administration records. These showed people had received their oral medicines as prescribed. However, we saw for one person there were gaps regarding the administration of topical pain relief and for another person gaps regarding the administration of a nutritional supplement. Therefore the records did not confirm these medicines had been administered as intended by the person who had prescribed them.

There was no system in place to check that people received the correct diet. This had meant that one person had been fed the wrong food on a number of occasions and the registered manager was not aware of this. Where people required the food intake to be monitored this was not always sufficiently recorded. This meant staff would not have been able to establish from these records whether people were at risk of not eating enough. People's fluid intake was recorded however there was no guidance for staff regarding what was a sufficient fluid intake for each person and these were not analysed over a period of time to ensure people had received enough to drink.

Timely action had not always been taken to manage risks regarding the premises. The fire service had inspected the home in September 2015 they advised that the exit door to the home needed to be amended so it could be easily opened without the use of a key. We saw a fire risk assessment carried out by an external company at the beginning of April made the same recommendation. At the time of our inspection records showed this had still not been actioned. The fire risk assessment also said regular checks needed to be carried out on the home's emergency lighting and fire extinguishers. At the time of our inspection this had not been put in to place. Issues regarding water temperatures not meeting the required temperatures had not been identified and action had not been taken to address this.

The above information meant there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with told us the registered manager was approachable, open, and listened to them. One relative told us the registered manager asked them and others about how they could improve the service. A member of staff said, "[management] really do listen to me." Staff meeting minutes showed the registered manager sought staff opinion regarding changes and issues with the service. A member of staff confirmed this and said that the management team worked with staff. This showed there was an open and inclusive culture in the home.

The registered manager had put in to place regular resident and family meetings so that people could be aware and involved in the service. People's views and opinions were sought. The registered manager told us they had redecorated the corridors in each wing of the home and people had chosen the 'theme' for how the corridors should be decorated.

Staff spoke positively about the registered manager and their leadership. Staff told us the registered manager was supportive. A staff member said, "[management] won't let us down."

The registered manager ensured staff knew their responsibilities and took accountability. A member of staff told us that the registered manager ensured staff knew who was responsible for what and communicated any changes to their role. Staff meeting minutes showed the registered manager discussed their expectations regarding the care that staff provided and were clear with staff on any issues requiring improvement. One member of staff told us the registered manager was fair and ensured issues regarding poor practice was addressed. Another staff member told us the registered manager had improved the standards of care in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Not all risks to people were regularly reviewed, managed or reduced. Regulation 12. (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014. Safeguarding service users from abuse and improper treatment. How the regulation was not being met: Systems did not operate effectively to ensure safeguarding concerns were reported as required. Regulation 13. (1) (2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014. Good Governance.

How the regulation was not being met:
The provider had not identified some areas where actions for previously required improvements were still outstanding or had not been appropriately maintained.

The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service.

The service did not maintain an accurate and complete record in respect of each person who used the service.