Gainsborough Care Home Limited

Gainsborough 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection visits took place on 10 and 16 March and we spoke with relatives by phone over the following week.

Gainsborough Care Home is a purpose built home registered to provide care for up to 45 people in a residential area of Swanage. At the start of our inspection there were 42 people living in the home. The majority of people living in the home had complex care needs related to the impact of their dementia.

The service did not have a registered manager at the time of our inspection but the manager was in the process of applying to take on this role. The last registered manager had left the service in December 2015 and the current manager had started in post at this time. 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.

Gainsborough Care home had been through a sustained period of management change when we inspected. The new manager had been in post for three months and was applying to become the registered manager. We found a number of areas that required improvement during our inspection. The manager was aware of most of these issues and had started work on plans to make improvements.
People did not always receive the support they needed to eat and drink in ways that met their needs and preferences. We observed that for some people meal times were an opportunity for choice and socialising but this was not the experience for people with more complex needs.

We heard some mixed opinions from relatives as to whether there were always enough staff available and we observed times when staff were not deployed in ways that met people's identified needs. The staffing had been reviewed and increased since the manager came into post and remained under review. Changes to deployment were made immediately following our inspection.

People were protected from harm because staff understood the risks they faced and knew how to identify and respond to abuse. Care and treatment was delivered in a way that met people's individual needs but there was some discrepancy about staff understanding of how to mitigate risks and records were not always accurate. This increased the risk that people could receive inappropriate care. Where people needed to live in the home to be cared for safely and they did not have the mental capacity to consent to this Deprivation of Liberty Safeguards had been applied for.

Some people were engaged with a wide range of activities that reflected individual preferences, including individual and group activities. Activities were being developed further with a focus on people who spent more time upstairs.

Health professionals were confident that people received support for their health related needs in a timely and appropriate manner.

People and their relatives were positive about the care they received from the home and told us the staff were compassionate, kind and attentive. Staff treated people, relatives, other staff and visitors with respect and kindness throughout our inspection. Relatives told us they felt able to raise concerns and that the new manager had made themselves available.

There was a breach of regulation relating to how people received care and support that met their needs. You can see the action we asked the provider to take at the back of the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Relatives had mixed views regarding whether staff were always available to meet people's needs and we observed situations when staff were not deployed in ways that met people's needs.

People were protected by staff who understood their role in keeping them safe.

People were supported by staff who understood the risks they faced but did not provide consistent support in response to these risks.

People received their medicines as prescribed.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

People were not always supported to eat and drink in ways that reflected their needs.

Deprivation of Liberty Safeguards (DoLS) had been applied for people
who needed their liberty to be restricted for them to live safely in the
home. Decisions about people's care were made within the framework of the Mental Capacity Act 200.

People were cared for by staff who felt they had received the training they needed to meet the needs of people in the home and felt supported. The manager had highlighted areas of training and support that needed development and had plans in place to ensure these happened.

Health professionals were confident in the staff's ability to identify health concerns and seek appropriate support for these.

Is the service caring?

Requires Improvement

There was a commitment to promoting dignity and person centred care but this was not always the experience of people

living in the home.

People were supported to make some choices but there were also times when people were not supported to make choices or communicated with effectively.

Is the service responsive?

Requires Improvement

People received care that was responsive to their individual needs. Care plans were not all accurate and work was being undertaken to ensure they were maintained effectively. Handovers were being used to ensure that staff were up to date with people's current needs.

People were able to take part in varied activities and there was work being undertaken to ensure that these were available to everyone. At the time of our inspection some people had less access to the activities because they spent more time in the newly opened upstairs lounge.

People and their relatives were confident they were listened to and complaints were responded to effectively.

Is the service well-led?

Requires Improvement

The manager had the confidence of people, staff, relatives and professionals following a period of management change.

There were systems in place to monitor and improve quality and these were effective in ensuring positive change.

Gainsborough 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.

This inspection took place on the 10 and 16 March and was unannounced. The inspection team was made up of two inspectors and a specialist adviser. The specialist adviser had expertise in mental health and risk and care management.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. The provider had not been asked to complete a Provider Information Record (PIR). A PIR 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 were able to gather the information contained in this form during our inspection.

During our inspection we spoke with eight people living in the home, some of whom did not always communicate effectively with words due to their dementia. Because people could not describe the care they received, we observed care practices and 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 also spoke with five visiting relatives and 11 members of staff. We also looked at records relating to 12 people's care, and reviewed records relating to the running of the service such as staff records, rotas and quality monitoring audits. Following the inspection visits we spoke with a further eight relatives by telephone.

We also spoke with four social care professionals and three healthcare professionals who had worked with the home or had visited people living at the home.

Requires Improvement

Is the service safe?

Our findings

Some risks people faced were managed effectively but there were also examples of risk management that was not sufficiently robust to protect people. Staff described the risks people faced consistently however they were not consistent in their understanding of how those risks were minimised. For example staff had differing views of what measures were in place to protect people from identified risks of developing pressure sores. One person's care plan said they needed "regular checks, turns and pad changes". The manager told us regular meant two hourly, a senior staff member told us this meant hourly and records indicated that they sometimes experienced intervals of four or more hours between these checks. In the three days prior to cream being prescribed for sore skin there were intervals of four or more hours between recorded checks on each day. There was a risk that the records reflected the care the person had received and that this may have contributed to the development of sore skin. Another person was described as needing two hourly turns when in their bed. Their records also indicated gaps of more than four hours between checks. Whilst their skin was in good condition inaccurate and incomplete recording heightened the risk of them receiving unsafe care. We discussed this with the manager who had previously identified recording as an area that needed more development. They detailed how they had started to address this training need in the staff team including through staff meetings, visiting professionals and supervision.

The number of falls in the home had reduced following the allocation of named staff to the communal lounges. A visiting health professional and a relative with professional knowledge commented positively on the management of risk associated with falling that had been introduced in the home. The relative described care saying: "They respect (name) wishes whilst keeping them safe." We observed people being supported to walk as described in their care plans and saw that there was always a member of staff in the downstairs communal lounge. However whilst staff described two people who we observed in the lounge upstairs as at high risk of falls there were times when this lounge was not attended for up to 15 minutes and both people were seen trying to move on their own. One of them got up and left the room having initially been invited to go downstairs but having then been left behind. They were visibly confused by the verbal instructions they were given and continued to try and leave the area before being brought back and encouraged to sit back down by a different member of staff. The other person tried to get up but they couldn't as they had a table placed in front of them and were restrained from moving as a result. The table had been put there with a drink on it but this could have been placed alongside them as we had seen at another time during our inspection. People were at risk of receiving care that did not mitigate the identified risks they faced sufficiently and did not reflect the law around restraint.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff were not always deployed in a way that met people's needs. During our inspection there were times when staff were not available to people when they needed them. Five relatives told us they had concerns about staffing levels. They told us sometimes they waited for bells to be answered or saw people in difficulty and alerted staff to this. One relative gave an example of visiting their relative and finding them ready for bed at 4:30 pm and another time they were not dressed at 11:30am. They told us their relative told them this was

due to staffing. We observed situations where staff deployment had an impact on the care people received. For example two people who were described as being at high risk of falls were unattended in a communal room where staff told us there should be a member of staff present. They tried to get up and move themselves during this time. We also saw one member of staff supporting everyone who had remained upstairs to have their lunch. We saw them prompting people one of whom was agitated whilst assisting three people to eat in the lounge. They then went to support people who needed assistance to eat in their rooms.

We spoke with the member of staff who told us that this was not usual and that there were normally two members of staff present. Staff also told us that when they were stretched that the manager and deputy manager stayed on and worked alongside them. We discussed staffing levels with the manager and they described changes they had made since coming into post. These included two increases in staffing which they had shared with relatives at a meeting for residents and relatives. They told us that staffing levels remained under review and that they would allocate named staff to support people with their meals. We received feedback from a social care professional that this had been done. Staff were recruited in a way that protected people from the risks of being cared for by staff who were not suitable to work with vulnerable people.

Most of the people living in the home were living with dementia and did not used words to communicate their emotions and could not tell us whether they felt safe. We saw that they were relaxed with staff; often smiling when staff were with them. The majority of relatives we spoke with shared a confidence that their relative was safe. One relative told us, "I feel confident (person's name) is safe." Staff were able to describe how they protected people from the risks of abuse by describing the signs they needed to be aware of and knowing where they would need to report any concerns they had. A social care professional with expertise in safeguarding had attended a recent staff meeting and this had given staff an opportunity to develop their knowledge and understand the role of those who investigate potential abuse. One member of staff described their commitment to ensuring they carried out their duties by saying: "It's about vulnerable people- their safety is in our hands."

People were given their medicines as prescribed during our inspection. They were given in ways that suited the individual and communication supported the person's understanding and independence. For example one person with advanced dementia had the colour of their tablets described whilst another person who had capacity to make decisions about medicines was asked if they wanted pain relief. Medicines were stored securely but the temperature in the storage room was consistently over 25 degrees centigrade. This can put medicines at risk of not working effectively. We raised this with the manager who told us they would be able to move the majority of medicines to a cooler locked room immediately and we were sent details after our inspection of plans to add a ventilation system to the medicine's storage room. We checked the contents of three medicines that were being given directly from the packet and found that one tablet could not be accounted for. The medicine was prescribed to reduce anxiety and agitation and was only to be given when needed. It was not clear if this medicine had been taken by the person or an error had been made. There was a risk that either the person had needed this medicine and there was no record of their distress at this time or that the medicine had been lost or given in error.

Requires Improvement

Is the service effective?

Our findings

People, relatives and staff all told us that the food was good. One person told us," The food is very nice." A relative told us that their relation liked the food and described them as "thriving" on it. The chef was keen to ensure that people enjoyed the food and attention had been paid to getting people to eat at tables in the dining room and making a more social event out of meals. High tea was now served daily with a choice of cakes and yoghurt for those who couldn't eat cake served on tiered cake stands. For people with less complex needs meal times involved choice and the opportunity to be social. One person asked for a sherry whilst waiting for their meal and this was brought quickly. Another person was not able to make a choice verbally so they were shown two meals and were able to choose their dinner. The meal time experience was not however satisfactory for some people with more complex support needs. Most relatives were happy with the support their loved one received to eat and drink but two relatives raised concerns about this. One commented that they had arrived to find their relation's meal uneaten in the afternoon.

During our first visit staff started to get people to the table 15 minutes before food started to arrive in the downstairs lounge. This was too long a wait for some people and they started to get up and leave the area. This was coordinated more smoothly on our second visit but one person's lunch was forgotten and they received their food after getting a staff member's attention 20 minutes after other people began to eat, they then waited a further few minutes to be assisted. People who ate upstairs received their food after those downstairs. People were again sat at tables, or in armchairs, waiting for food which took up to 35 minutes to arrive after the knives and forks were placed in front of them. The cutlery was a visual prompt that a meal was about to happen a substantial period of time before it did. People who needed support received this sporadically and we noted that one person did not receive the help they needed to eat their meal. It was removed on the first day after they had eaten one mouthful. On the second day they ate a few mouthfuls when assisted by staff but the staff member did not stay with them and they were unable to coordinate to feed themselves in between assistance. This person was losing weight and receiving input from the dietician. They did not receive the assistance they needed to eat and records were not completed in respect of their food intake. In the upstairs lounge people were assisted to eat by one member of staff who was also supervising people sitting at the table. This resulted in them being fed by a staff member who was usually standing next to them and whose attention was often with other people. Food was offered at regular times throughout the day and snacks were available during the night. We spoke with the management team about meal times and the manager told us they would ensure that people who need assistance would have a named person allocated to support them as of the next day.

People were not supported at meal times in an appropriate way to meet their needs and preferences because their meal times were not planned and delivered effectively.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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 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 a person of their liberty were being met.

People's care plans reflected the principles of the Mental Capacity Act 2005 (MCA) with consent sought appropriately in most plans we looked at and best interest decisions made where people were unable to consent to their care. Letters had been sent to relatives explaining this law and the way it frames the care people received. Best interest decisions included reference to relatives views but we also heard form a relative whose contribution had been recorded that they had not been asked specific questions or seen the care plan of their relation. We discussed this with the member of staff responsible for care planning and they acknowledged that this was the case. They ahd had used the relatives overall views as evidence for the best interest decision. This approach could miss important information about how a person would like their care to be delivered. We also found examples of good information for staff about people's ability to make decisions and information about how to support someone if they refused their care. Staff were able to describe how they supported choice with some people and the approaches they took when people refused care. We also saw that sometimes opportunities to promote decision making were missed by staff who made well intentioned assumptions about what people wanted. The manager highlighted that MCA training was a priority for staff and there were plans in place for this.

The home had applied for Deprivation of Liberty Safeguards (DoLS) to be authorised appropriately. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely. We spoke with the paid representative of a person who was subject to DoLS, they told us they felt that the service respected their views and discussions about the person's care were ongoing and productive. They were given access to the person's records and supported to undertake their role for the person effectively.

People were supported to maintain their health. We spoke with two health professionals who had regular contact with the home and they spoke positively about improvements in the health support people received. Both told us they believed they were called in a timely manner and that guidance given to the staff was followed correctly. One referred to a multidisciplinary meeting that they attended with the management of the home. They told us this had been set up to address issues of concern but was now utilised as an improvement forum. Relatives were mostly confident in the support their loved one received. Four visiting relatives spoke strongly about their belief that their loved one was receiving appropriate health support and that the staff had supported this to happen. We also heard an example of a person not receiving health support quickly and this instance the relatives felt the staff had not responded appropriately. We spoke with the manager about access to health and she described she had reinforced the necessity of staff making managers aware of people's changing health needs following an identified failing to seek appropriate advice. They were confident that this now happened and we saw examples of this being the case.

Staff told us they felt supported to do their jobs and described how guidance from colleagues ensured they

were up to date with people's needs. There was a robust system in place to ensure that staff received their training and the provider had training facilities and resources available to staff. The Care Certificate had been introduced by the provider. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff supervision had not been kept up to date due to management changes in the home. The manager was aware of this and had a plan in place to ensure these were undertaken in a way that enhanced the supportive function of the sessions.

Requires Improvement

Is the service caring?

Our findings

Most people and relatives described the service as caring. One relative told us, "Its' wonderful here the carers are exceptional you never hear a cross word." Another relative told us "I think they are all really caring and (relation) has responded really well to all the staff." Relatives told us that this caring approach extended to them too. We were told: "They are full of empathy and that starts at the top." Another relative commented that the staff always had time to answer any questions they had.

There was a strong commitment to promoting person centred care and dignity amongst the management team and whilst we heard about and saw examples of this in practice it was not consistently the experience of people living in the home and this was an area for improvement.

Some staff were skilled at communicating and took time with people throughout our inspection; offering reassurance whenever necessary. We saw staff taking time to talk with people and to make a connection as they went about their tasks. This person centred approach had a visibly calming and mood enhancing effect on people. However, we also saw staff working in a task focussed way and not picking up on the cues of the person they were with. For example one person spoke in a cross voice to a member of staff who was dancing and clicking their fingers in front of them. They told them that there was no point talking to them as they were being silly. The member of staff carried on what they were doing and told the person bluntly that they weren't silly. This did not reflect a person centred approach and shut the person's communication down.

Staff talked about the importance of promoting independence and respecting people's wishes. One member of staff commented "I encourage people's independence and happiness." A person reflected this when they told us they enjoyed setting the tables. A relative also highlighted the importance of this respect describing how staff respected their relation's wishes and so allowed them to live how they chose to.

There were inconsistencies in how well people were supported to make choices during our inspection. People were supported to make some choices throughout the day such as what they wore, where they sat, what they ate and whether joined in activities. We saw examples of people being shown different foods and items of clothing to choose between. These choices were not always available though and we saw people being given drinks and food without a choice or explanation also. One person whose care plan described them as liking socialising was given a drink without any interaction at all. Another person was being assisted to eat by a member of staff. We asked what the food was as they hadn't told the person and the staff member did not know. One person's care plan described that they may be able to make more decisions about their care if their communication was supported by picture cards. This care plan had been put in place more than a month before our inspection but there were no picture cards available. This meant that the person may have been able to make choices and communicate but that this had not been facilitated.

The home was part of a small community and many of the people living there knew one another or the staff. This community feeling was further enhanced by events for people, their friends and families as well as a welcoming approach to visitors. For example Easter events were planned and the home had recently run a poetry competition open to everyone to mark a national dignity day. The winning poems would be framed

and put up. The home also put a regular article into the local newspaper. The manager explained that there were many benefits to being part of a community in this way but they were aware that it meant staff needed to be especially vigilant about confidentiality and this was reinforced.

During our inspection one part of the home smelled strongly of urine and this did not promote the dignity of people who lived in this part of the home. We raised this with the manager and the area did not smell when we visited for our second day.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed and recorded alongside plans to meet these needs in their records. These plans were being reviewed and updated at the time of our inspection as part of a planned piece of work. At the time of our inspection 17 of the care plans had been updated, but some of the plans were not up to date and did not reflect current need. For example one person had a care plan that said they could feed themselves but they now needed staff to assist them with their food. The manager explained that whilst care plans were being updated that the handover was providing a robust framework to ensure staff understood people's needs and that they discussed people's care in a person centred way each day. This process was largely effective although we came across examples of staff having different understandings of how risks were managed. For example staff were able to talk about what mattered to people, how to distract them if they were upset. Some relatives had not been appropriately involved in the assessments of their loved ones needs and the development of their care plans. One relative told us they were kept informed but did not feel consulted.

People were responded to sensitively if they became distressed or agitated. For example a member of staff sat with a group and began to do some colouring with them whilst helping them through some challenging group dynamics.

Activities were planned for groups and individuals with a guide to what would be on in the week displayed in written format in the entrance of the home. Whilst the format was not accessible for some people one person told us they had been keeping an eye on it but had missed the activity they wanted as they had not been able to work out which room it was in or what time it would be happening from the program. The program was varied and afforded people the opportunity to take part in a range of activities such as: tai chi, discussion about current events and receiving visits from a Pets as therapy (PAT) dog. Relatives told us there had been a marked increase in activities and felt this benefitted people. During our visits musical entertainers came in and spent the afternoon in the downstairs lounge. Most people in the room joined in and sang along. The manager had also started to develop activities boxes which contained a range of materials such as a tactile ball and colouring books. These were kept in both lounges and were accessible to staff or relatives to use to engage with people. At the time of our inspection these were beginning to be used but some people were still spending the majority of their time sitting with the television on. We sat down between two people in the upstairs communal lounge and both people started to talk with us straight away and continued to do so for the time we remained seated. We saw that one of these people was described as liking to socialise in their care plan but we did not see staff engaged in conversation with them during the times we were in this area. On one occasion the member of staff allocated to this room stood in the door way observing people rather than engaging with people. This meant people were missing out on social stimulation. We discussed activities with the manager and they explained they had plans to increase the activities available for people who stayed upstairs. This lounge had not been open for long and before that most people, who did not stay in their rooms, had joined communal activities regularly. They told us they continued to work on this area of people's experience and had spoken about it with relatives and staff.

The management team had a positive attitude to complaints and mistakes. People and relatives told us they would be comfortable to raise any concerns they had with the managers. One relative told us that they always got a reply to any queries or concerns they raised. Another relative described how they had been able to discuss their concerns at a relatives meeting. They were confident that progress was being made in sorting out their concerns. One relative described how they felt about raising concerns stating: "We feel absolutely able to raise any issues." There had been a complaint received in the month prior to our inspection. Due to the nature of the complaint the manager raised it with the local safeguarding team. This was an appropriate response which reflected an open approach to responding to concerns.

Requires Improvement

Is the service well-led?

Our findings

Gainsborough care home had been through a period of unstable management. Relatives and staff all referred to this during discussions but identified that they felt confident in the current manager's commitment and capabilities. One relative told us: "There have been five managers in two years but (manager's name) seems committed. There is a sense of direction." The last registered manager had left in December 2015 after registering with the commission in June 2015 and the current manager was in the process of applying to take on this statutory function. People recognised the manager and were comfortable with them and we observed residents, staff and relatives talking with them throughout or inspection. One person said "No one could be better when describing them. The changes in management had left some relatives feeling unsure but they described the confidence that having the manager's number and seeing the manager there at varying times of the day and week had given them. Professionals were also positive in their description of the service and identified the senior team as having been instrumental in making changes to improve communication and care.

There were systems and structures in place to ensure that the quality of service people received was monitored and improved. For example there were audits and reviews undertaken by senior staff and meetings scheduled to ensure consistency and shared understanding. Where audits had taken place they were effective in ensuring change. For example, an audit of medicines had led to changes in the system that made it safer and infection control audit had led to environmental changes and a staff records audit had identified a need to address a shortfall in supervisions and a plan to address this was in place. A review of accidents and incidents had also led to changes in staff deployment resulting in a reduction of falls in communal lounges. Some issues had not been picked up for example an environmental audit that took place in February 2016 had not picked up trip hazards associated with the wear of an upstairs corridor carpet. We showed the manager the places where the carpet had worn through and they told us they would seek a quote to replace them at once. The audit had picked up a strong smell of urine in one area of the home. This had been addressed but during our inspection there was a strong smell in another part of the home. We highlighted this and it was addressed before we returned for our second visit. The staffing allocation that had reduced the risk of falls in lounges was not being implemented effectively during our inspection. There was a risk that where concerns were identified through quality assurance processes adequate checks were not in place to ensure that the identified actions were introduced in a sustainable manner. We had discussed challenges facing the service with the manager. They told us that maintaining close monitoring of people living in the home was one of the biggest challenges and described the ways they were addressing this. They acknowledged this along with other areas as work in progress but expressed confidence and showed evidence that improvements were being made.

The management team were responsive and proactive in their work with other professionals. A monitoring visit by the local authority had taken place in December 2015 and this had resulted in a number of recommendations. The manager had an action plan in place to address these and progress was evident during our inspection. For example spot checks had been undertaken and care plans were all being reviewed with 17 completed. We also received an action plan following our feedback at the end of the inspection identifying a range of actions already taken and some that had been scheduled. One of the

actions identified was the monitoring of meal times to review the risks and devise an appropriate response. An initial response was ensuring named staff were responsible for supporting people with their meals.

The manager told us they were well supported by the provider organisation. They also spoke highly of the staff identifying the difficulties they had faced with changes in management expectations over the previous two years. They told us the staff team were very supportive, hardworking and responsive. This respect was reflected in how the staff viewed the management team and how they understood their purpose. One member of staff told us "I feel part of a team. It is all for the residents."

Meeting minutes reflected the open approach the management team were aiming to promote with open agendas to facilitate discussion about staffing concerns and focussed practice based discussion around care issues such as ensuring oral and nail care. Relatives had also been included in this approach with a meeting dedicated to outlining the manager's ethos and practical plans alongside promoting an open door policy. We saw relatives had responded to this and they came top share concerns and appreciation during our visits.

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 did not take formal enforcement action at this stage. 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 People were not protected from harm because where risks were identified the provider was not doing all that was reasonably practicable to reduce these risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not provided with the necessary support to eat or drink.