Hinckley Care Limited

The Ashton Care Home

Inspection report

John Street
Hinckley
Leicestershire
LE10 1UY

Tel: 01455233350

Date of inspection visit:
11 December 2018
12 December 2018

Date of publication:
28 January 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 Ashton 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.

The Ashton Care Home is located in the town of Hinckley, Leicestershire. It provides accommodation for up to 72 people who require nursing or personal care. Accommodation is provided on three floors. Residential care on the ground floor, dementia care on the first floor and nursing care on the second floor. On the day of our inspection there were 64 people using the service.

We inspected The Ashton Care Home on 11 and 12 December 2018. The first day of our visit was unannounced. This meant the staff and the provider did not know we would be visiting.

At the last inspection in September 2016, the service was rated Good. At this inspection we found the service Required Improvement.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Appropriate numbers of staff had not always been suitably deployed to meet people's needs in a caring, safe or timely manner.

Systems in place to monitor the quality and safety of the service being provided were not always effective.

Care records kept to demonstrate people were being supported in line with their plan of care were not always accurate, up to date or completed.

The providers infection control policy had not always been followed. Protective personal equipment, such as disposable gloves and aprons were readily available, though not always used.

People's needs had been considered prior to them moving into the service and the risks associated with their care and support had been assessed and managed.

There were arrangements in place to make sure action was taken and lessons learned when things went wrong, to improve safety across the service.

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.

Appropriate checks had been carried out when new staff members joined the service and relevant training had been provided. Not all of the staff team had received training on how to support people at the end of their life. We have made a recommendation about this.

The staff team supported people to make decisions about their day to day care and support. They were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) ensuring people's human rights were protected. Where people lacked the capacity to make their own decisions, these had been made for them in their best interest and in consultation with others.

People's food and drink requirements had been assessed and a balanced diet was being provided. People received on-going healthcare support and had access to the relevant healthcare services.

People told us the staff team were kind and caring and treated them with respect.

The staff team felt supported by the registered manager and the senior team and told us there was always someone available to talk with should they need guidance or support.

People were supported with their medicines in a safe way. Systems were in place to regularly audit the medicines held and the appropriate records were being kept.

People were provided with a clean and comfortable place to live and there were appropriate spaces to enable them to either spend time with others, or on their own.

Relatives and friends were encouraged to visit. People were provided with the opportunity to have a say and to be involved in how the service was run. Regular meetings had been held and surveys used to gain people's feedback.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered 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 consistently safe.

Sufficient numbers of staff were not always deployed in order to meet people's care and support in a safe or timely way.

Staff understood their responsibilities for keeping people safe from avoidable harm.

The providers infection control policy was not always followed.

Risks to people had been assessed and managed and lessons were learned when things went wrong.

Is the service effective?

Good

The service was effective.

People's care and support needs had been assessed prior to them moving into the service.

People were supported to maintain a balanced diet and were assisted to access health care services when they needed them.

People's care and support needs were met by the adaptation, design and decoration of the premises.

People's consent to their care and support was sought and the staff team understood the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staffing numbers meant the staff team had little time to focus on people's wellbeing.

The staff team were kind and caring and treated people with respect.

People were supported to make decisions about their care and support on a daily basis.

The staff team respected people's personal preferences and choices.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Records did not demonstrate people's plans of care were always followed.

People who were able had been involved in the planning of their care with the support of their relatives.

There was a formal complaints process in place and people knew what to do if they were unhappy about anything.

People's wishes at end of life were being explored. Not all of the staff team had received training in how to support people at the end of life.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Monitoring systems used to check the quality of the service being provided were not always effective.

People had been given the opportunity to share their thoughts on how the service was run.

The registered manager worked in partnership with other organisations including the local authority and safeguarding team.

The Ashton 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, which had been brought forward due to concerns we received regarding the staffing levels at the service, was carried out by three inspectors, a specialist nurse advisor 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 care service. Their area of expertise was people living with dementia.

Prior to our inspection we reviewed information we held about the service such as notifications. These detail events which happened at the service that the provider is required to tell us about.

We contacted the health and social care commissioners who monitor the care and support of people receiving care at The Ashton Care Home to obtain their views of the care provided. We also contacted Healthwatch Leicestershire, the local consumer champion for people using adult social care services to see if they had any feedback about the service. We used this information to inform our inspection planning.

At the time of our inspection there were 64 people living at the service. We were able to speak with 13 people living there and seven relatives. We also spoke with the registered manager, one member of the senior management team, 15 members of the staff team and a visiting health professional.

We observed support being provided in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included eight people's plans of care. We also looked at associated documents including risk assessments. We looked at records of meetings, recruitment checks carried out for four staff members and the quality assurance audits the management team had completed.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection, we had received a number of concerns regarding the staffing levels maintained at the service. During our visit, we checked the staffing rotas and the staff allocation book to check the numbers of staff available on each shift. On numerous occasions the allocations book showed, due to staff sickness, shifts were not fully covered. The provider often ran short of staff or staff members were required to work between floors in order to meet people's care and support needs. For example, we were told there should be six support workers and one nurse working at night. On the 27 and 28 November 2018, there were only four staff members recorded in the allocation book and on the 1st December 2018 there were two staff members down on the morning shift. This meant people were at risk of not getting their identified care and support needs met due to the shortage of available staff.

People told us there were not always enough staff on duty to meet their needs. One person explained, "Sometimes there are not enough [staff]. We have to wait a bit longer. It's all down to money, you can't blame the staff." Another stated, "Generally yes. Though there are times they are stretched."

Relatives shared their thoughts on the staffing levels within the service. One explained, "No there are not enough staff, especially at the weekends." Another told us, "No not enough staff. I have to come in and shower my relative."

Comments from staff included, "Down here [on the ground floor] three or four [staff] is enough. On Bennett [the dementia floor] sometimes they have a senior and two carers and I don't feel it is safe, on good days we will have a senior and three carers and that's ok we can manage." And, "I have no issues about staffing levels, there are a few days when we are short but we manage." And, "Four [staff on duty] is manageable, three is not enough." And, "I feel pressured due to lack of staff."

On the day of our visit a member of staff had called in sick. This meant the numbers of staff required to meet people's identified needs were not available. On visiting the floor where people predominately lived with dementia, it was noted there were only two members of staff available to support the people living there. They explained a member of staff had been required to support the staff working on the nursing floor as they were short staffed. A member of staff was required to stay in attendance in the lounge area at all times in order to keep people safe which meant there was only one person available to offer support elsewhere if needed. One staff member explained, "There is only two on the floor at the minute and we really need a minimum of four or five. We try our best to give personal care and that is why we are sometimes late for breakfast. [Person] took 45 minutes yesterday. [Staff member] was here but they have now gone upstairs so there is only two of us. This happens frequently."

It was evident staff were struggling to meet people's overall needs and complete the necessary documentation associated with people's care and support. There was an electronic recording system in place to record there and then, when interventions such as the repositioning of people were carried out. Repositioning is carried out when people are at risk of causing damage to their skin. Records checked showed people's plans of care were not always being followed with regard to their need to be repositioned.

For example, one person required to be repositioned two hourly when in bed. On numerous occasions we identified in their records where they had gone over four hours between being repositioned. A member of staff explained, "There's just not enough time to complete the records on the computer."

We discussed this with the registered manager. They acknowledged they were at times struggling to staff the service due to continual sickness. They had recently taken on 16 new members of staff and it was hoped this would alleviate the situation.

The provider failed to ensure there were adequate staff to provide care and treatment to people. These matters constituted a breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The provider's recruitment process had been followed when new staff members had been employed. Previous employment had been explored, references had been collected and a check with the Disclosure and Barring Service (DBS) had been carried out. A DBS check provided information as to whether someone was suitable to work at this service. For the nurses working at the service, a check with the Nursing and Midwifery Council (NMC) had also been carried out to make sure they had an up to date professional registration. Nurses can only practice as nurses if they are registered with the NMC.

Risks associated with people's care and support had been identified and assessed when they had first moved into the service. Risks assessed included those associated with the moving and handling of people, people's nutrition and hydration and the risks of falls. These risks had been reviewed in a timely manner. For a person identified at risk of choking, a speech and language therapy assessment (SALT) had been completed and recommendations made were being followed.

Regular safety checks had been carried out on the environment and on the equipment used. Checks had been carried out on the hot water at the service to ensure it was delivered at a safe temperature and yearly checks had been carried out on the portable appliances used, to check they remained in good condition.

People felt safe living at The Ashton Care Home and felt safe with the staff team who supported them. One person told us, "Yes I feel safe. If I fall over, I know someone will help me." A relative explained, "I feel [person] is safe and happy and we have peace of mind when we leave."

The staff team had received training in the safeguarding of adults and knew their responsibilities for keeping people safe from avoidable harm.

The provider's medicine policy was followed when people were supported with their medicines. Records were clearly completed to show medicines were administered regularly. Medicines administration records (MARs) contained a photograph of the person to aid identification and a record of allergies and the person's preferences for taking their medicines was also included. Protocols were in place for people prescribed medicines 'as and when required' such as for pain relief, giving clear instructions about when and why the medicines were being given. An appropriate system was in place for the receipt and return of people's medicines and an auditing process was carried out to ensure people's medicines were handled in line with the provider's policies and procedures. One of the people using the service told us, "I take medication. Sometimes they are late. I am not affected when they give my medication late though."

For one person who had been prescribed an ointment by their GP, this had not been made available to them in a timely manner. This was because the person dealing with the medicines had been away from work. We also noted support workers were not signing the MAR when applying creams or ointments. We

shared this with the registered manager for their attention and action.

Support workers were not always adhering to the provider's infection prevention and control policy. During our visit we observed one staff member transporting soiled bedsheets through the service. They neither used a bag to transport the sheets in, or used protective gloves or aprons. We also noted soiled continence pads were not placed in bags prior to being put in the bin and the bin was without a lid. These instances increased the risk of spreading infections.

We recommend the staff team are reminded of the importance of following the providers policy on infection prevention and control and best practice guidance.

The staff team were encouraged to report incidents that happened at the service and the registered manager ensured lessons were learned and improvements were made when things went wrong. For example, the staff team's response to a recent fire alarm had not been robust and a family member made a complaint. The registered manager met with the family and drew up an action plan and workshops were carried out with the staff team regarding how fire drills should be conducted. This ensured the staff team knew their responsibilities moving forward.

Good

Is the service effective?

Our findings

People's individual, cultural and diverse needs had been assessed prior to them moving into the service. The registered manager completed an initial assessment to make sure people's needs could be met by the staff team working there. Expected outcomes had been identified and these were being monitored. It was evident during our visit the staff team knew the needs of the people they were supporting well.

The staff team were supported by a range of health care specialists and care, treatment and support was provided in line with national guidance and best practice guidelines. People had access to external healthcare services and received on-going healthcare support. The staff team were observant to changes in people's health and when concerns had been raised, support from the relevant healthcare professionals such as the GP and community nurse had been sought in a timely manner.

People received care from a staff team that, on the whole, had the skills and knowledge to meet their individual needs. Staff members explained they had received an induction when they had first started working at the service and relevant training and regular updates had been received. This included training in the safeguarding of adults, moving and handling, health and safety and equality and diversity. This meant the staff team could support the people using the service safely and effectively. One staff member explained, "I did training on line, I did a multitude of training including end of life and dementia training." Another explained, "I had an induction then I observed the other carers. The manager asked me if I was comfortable doing things before I did it on my own, I was. I'm doing medicine training tomorrow." One of the people using the service explained, "For me they are competent. They know how to deal with my [health condition]."

We checked the providers training records. A variety of training had been provided and the registered manager was in the process of updating the training available using the services of a local college. Nurses working at the service had been supported by the registered manager to meet their requirements for revalidation and maintain their professional registration.

The staff team told us they received support through supervisions, and where applicable an annual appraisal of their performance had carried out. Whilst supervisions had been provided, we noted not all of the staff team had received this support on a regular basis. For example, one person who had worked at the service for seven months had so far only received one session of supervision. The registered manager was in the process of addressing this.

The staff team worked together within the service and with external agencies. This was to ensure key information was provided to medical staff when people were transferred into hospital so their needs could continue to be met.

People were supported to maintain a healthy balanced diet and people told us the meals served at The Ashton Care Home were good. One person told us, "The food is alright and there is enough choice." Another explained, "The menu is a bit repetitive but it is OK. I have eaten more here than at home." There was a

choice of meals each day and alternatives were available should anyone wish for something different. There were snacks and drinks available throughout the day.

The chef, had information about people's dietary needs. They knew about the requirements for people who needed a soft or pureed diet and for people who lived with allergies. They worked well with healthcare professionals and followed their specialist advice with regard to people's food intake.

Nutritional risk assessments and plans of care were developed for people's eating and drinking requirements. Where people had been identified at risk of not getting the food and drink they needed to keep them well, charts had been completed. The charts seen had been completed daily. What had been offered and taken had been recorded within the charts and the reasons why food and drink had been declined had also been documented.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager was working within the principles of the MCA. The staff team had received training in the MCA and DoLS and they understood their responsibilities within this.

People were encouraged and supported to make decisions about their care and support on a daily basis. During our visit we saw people choosing how to spend their day, whether to attend a social activity and what to eat and drink. Staff supported people who did not have capacity to make decisions, in the least restrictive way possible. People were supported to have maximum choice and control of their lives and the policies and systems in the service supported this practice.

The premises were adapted to meet people's needs. There were a variety of communal areas of differing sizes to allow people to be with a large group of people and to facilitate group activities or quieter areas where people could be alone. Good signage for facilities such as bathrooms and toilets aided identification for people living with dementia. We did note a malodour in the corridor on the dementia floor. The registered manager acknowledged this and explained a plan was in place to improve the environment on the dementia floor.

Requires Improvement

Is the service caring?

Our findings

Whilst people told us the staff team were kind and caring, staffing numbers meant people could not always be cared for well. The staff team were focused on the task in hand and had little time to focus on people's wellbeing. The staff team did not always have the time to recognise and give people the compassionate support they needed or have the time to sit and talk with people for a meaningful length of time. This was particularly evident on the dementia floor. We shared this with the registered manager for their attention and action.

It was evident during our visit that a member of the staff team was unwell. They explained they had tried to call in sick without success. They had arrived at the service to explain they were unwell and unable to work. They were told they had to stay and assist people to get up even though they were unwell. This staff members wellbeing had not been taken into consideration.

People told us the staff team were kind and considerate and they looked after them well. One person told us, "Very well [looked after], they can't do enough for you." Another stated, "They are very friendly, very nice."

Relatives we spoke with agreed their family members were treated in a caring manner. One explained, "Yes they are kind and compassionate to my relative."

The staff team had the information they needed to provide individualised care and support. They were knowledgeable about people's life history. They knew people's preferred routines and the people who were important to them. They knew their likes and dislikes and personal preferences including what they liked to be called.

Staff members gave us examples of how they maintained people's privacy and dignity when they supported them with personal care. One staff member told us, "I make sure the curtains and door are closed. I ask if they are comfortable and tell them what I am doing." One of the people using the service explained, "They treat me in a respectful and dignified manner." A relative added, "They treat them [people using the service] with dignity, respect and humour."

We observed people being supported throughout our visit. Staff had a good understanding of people's needs and they were seen supporting people in a kind and friendly manner. We observed staff knocking on people's doors and waiting for an answer before entering their rooms. We observed staff adjusting people's clothes and covering them to ensure their dignity.

People were encouraged to maintain relationships that were important to them. Staff had received training in equality and diversity and respected people's wishes in accordance with the protected characteristics of the Equality Act. People were treated fairly and equally. A staff member told us, "Everybody is treated equally no matter what their colour, background or gender." Relatives were made welcome and were able to visit at any time. One relative explained, "We can come at any time and are always made welcome."

Advocacy services were made available to people who were unable to make decisions regarding their care and support, either by themselves or with the help of a family member. This meant people had access to someone who could support them and speak up on their behalf if they needed it.

Requires Improvement

Is the service responsive?

Our findings

Whilst plans of care were in place, not all were being followed. For example, for a person who had been identified at risk of developing pressure ulcers they had been assessed as needing to be repositioned every two hours. The supplementary records showed this was not happening. On the 5th December 2018 it was recorded that they were repositioned four times in the 24-hour period. On 6 December 2018 it was recorded that they were repositioned five times in a 24-hour period and on 7 December 2018 it was recorded that they were repositioned five times in a 24-hour period. The person should have been repositioned approximately 12 times in each 24-hour period, this would equate to 2 hourly turns/ repositioning as described in their plan of care. This conflicted with what was written in their plan of care, therefore their repositioning charts were inaccurate and incomplete.

A further two people whose records we looked at had been assessed as high risk of developing pressure ulcers. Their plans of care stated they needed to be repositioned every two hours during the day and night or when in bed. When we checked their supplementary records, we found repositioning had again not been recorded as being carried out.

For two people who were doubly incontinent and assessed as high risk of developing pressure ulcers, no toileting regime had been devised. This meant there was no regular plan to follow to ensure they were supported with their continence needs.

One person's records showed on at 8.00am on 2 December 2018 they had been assisted with a full body wash and their continence needs attended to. The next entry was recorded at 19.00pm that evening. On the 11 December 2018 there was a 12-hour gap between interventions.

The second person's records showed they were assisted at 8.00am on 8th December 2018 to have a full bed bath, pad changed and assisted to get dressed. The next entry was at 19.35pm that evening which stated assisted into nightwear and pad changed as wet. It could not be determined how long this person had been sat with a wet pad.

Whilst it had been assessed that some people required the assistance of two staff members to safely assist them with their care and support needs, records showed they had at times been assisted by one person.

The records seen did not demonstrate people's care and support needs had being met in a safe or timely manner.

The provider failed to ensure they did all that was reasonable practicable to mitigate the risks of people developing a pressure ulcer. These matters constituted a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People plans of care covered areas such as, nutrition, mobility, and the personal care they required. They also covered people's health needs such as diabetes, or enteral nutrition (food given via a tube). They had

been reviewed on a monthly basis or sooner if changes to the person's health and welfare had been identified. Where changes in people's health had occurred, the appropriate action had been taken. This included for one person, who had difficulty swallowing, contacting the speech and language team for support.

Plans of care checked varied in content, with some being more comprehensive than others. We did note not all of the plans of care included all the relevant information. This included for one person with diabetes, the signs and symptoms to look out for should their health deteriorate. This was immediately addressed and the relevant information added. We also noted some support workers were unsure with the level of support another person needed. Whilst some staff spoken with explained they needed a piece of equipment to support them with their mobility, other staff members told us they did not. When we checked their plan of care, we saw they did not need the equipment, just their walking frame and a member of staff.

People had been involved in the planning of their care with the support of their relatives. A relative explained, "Yes it was quite quick [the assessment] due to need for my relative to find a home. However, we were well informed [about the service]." Another told us, "We were able to ask lots of questions."

People were supported to follow their interests and take part in activities. The service employed an activity coordinator who provided people with opportunities to engage in activities on a group or one to one basis. One person told us, "I liked reading and going for walks. I have continued the reading. I am not able to do the walking though." A relative explained, "There are activities but my relative is not really one for joining in." On the day of our visit, people enjoyed an afternoon of music from an outside entertainer.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider understood their responsibility to comply with the AIS and was able to access information regarding the service in different formats to meet people's diverse needs. The staff team knew people well and knew how each person communicated.

A formal complaints process was in place and people we spoke with knew who to talk to if they were unhappy about anything. One of the people using the service told us, "I did complain once about the breakfast being cold, It's OK now." A relative explained, "I complained once to the manager and it was acted on."

Conversations had been carried out with the people using the service and their family members regarding end of life care and advanced decisions were clearly documented in people's plans of care. We did note, whilst the staff training record showed some of the staff team had received training on supporting people at the end of their life, the majority had not. One staff member explained, "I feel it would be very beneficial for care assistants to have training in end of life care including what happens when a person dies and the role of the funeral director at the end of life."

We recommend end of life training be rolled out to all staff working at the service to enable them to feel comfortable and confident in supporting people at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. 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.

Whilst the registered manager had systems in place to monitor the quality and safety of the service being provided, these had not identified the shortfalls found during our visit.

The monitoring of staffing levels had not been effective to ensure appropriate numbers of staff were deployed to meet people's care and support in a safe and timely manner. Audits had not picked up the shortfalls within the supplementary records. For example, the charts showing when people required repositioning to support their skin care and how many support workers were supporting people as per their plan of care. Absence of information regarding the support two people required with their continence needs had also not been picked up.

The provider carried out an audit covering all aspects of the service being provided. At the last visit carried out on 30 July 2018, staff had commented on the shortage of staff with one explaining they felt stressed due to staff being short and the workload increased. There was no evidence to demonstrate this had been acted on.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

Regular audits to monitor the environment and on the equipment used to maintain people's safety had been carried out. This made sure people were provided with a safe place in which to live.

There was an electronic recording system in place to record in real time, the care and support people received. However, there were not sufficient numbers of devices available to the staff to enable them to complete documents as and when people were supported. One staff member explained, "There are not enough computers available for prompt recording of notes." We were told this was being looked into.

People told us they felt the service was well managed and the registered manager and the staff team were friendly and approachable. A relative told us, "[Registered manager] is the best manager so far. She is communicative, we like her very much." Another explained, "I would recommend the home. It is comfortable and well run."

People and their relatives and friends had been given the opportunity to share their thoughts of the service being provided. This was through regular meetings and informal chats. The registered manager had also used surveys to gather people's views of the service provided. One of the people using the service explained, "Yes we have resident's meetings, I don't go very often though."

Staff members felt supported by the management team. They told us there was always someone available to talk to if needed. One explained, "The manager is the best manager I've had." Another told us, "I do feel supported, [head of care] is very good, they will help you out with anything. [Registered manager], I can't fault her, she is very understanding."

Staff members were given the opportunity to share their thoughts on the service and be involved in how the service was run. This was through formal staff meetings, supervisions and day to day conversations with the management team.

The registered manager worked openly with stakeholders and other agencies. This included raising safeguarding alerts and liaising with social work teams and other professionals when appropriate, to ensure people's safety.

The registered manager was aware of their responsibility to have on display the rating from their last inspection. We saw the rating was clearly on display on the provider's website and within the service. The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Records did not demonstrate people received the care and support they needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems used to monitor the service were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff deployed to support people in a caring, safe and timely manner.