Leonard Cheshire Disability

Newlands House - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 27 September 2018 and was unannounced. Newlands House - Care Home is a is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides care in an accessible building including electronic door openings because everyone who lives there uses a wheelchair to mobilise. It is a care home for 35 people with physical disabilities and at the time of our inspection 32 people were living there. However, only 28 people were present as 4 were either on holiday or visiting family.

They were last inspected on 14 September 2017 and were found to require improvement. At this inspection they still required improvement.

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.

Risk was not always assessed and actions were not always considered to reduce it. The review of when things went wrong was not always thorough enough to reduce the risk of repetition. Some incidents which could have been reviewed independently as a safeguarding concern, had not been considered as such and had therefore not been reported to the relevant safeguarding authority.

People did not always receive personalised care which was based on their preferences. They also did not always have enough opportunity for meaningful engagement. Information had not been adapted to meet people's individual needs. Some information in care plans did not give enough guidance and daily records were not always fully completed. The audits and reviews conducted did not always fully consider this and ensure that people were at the centre of their care. Although there were enough staff to meet people's needs and this was kept under review, the audits did not consider the quality of interaction some people experienced.

Staff received training and support to enable them to fulfil their role effectively and were encouraged to develop their skills. They had developed caring, respectful relationships with people and ensured that their dignity and privacy were upheld. 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. The environment was planned to meet their needs and encourage independence.

People were assisted to maintain good health and had regular access to healthcare professionals. Medicines were managed safely and people received them when they needed them. Mealtimes included a choice of meal and people received patient support to assist them when needed. There were systems in the home to keep it clean and free from infection.

Visitors were welcomed at any time. People and their relatives knew the registered manager and felt confident that any concerns they raised would be resolved promptly. There were regular meetings with people which people told us they enjoyed and that they felt listened to. There were good relationships with other organisations and professionals; including working closely with commissioners to meet actions on improvement plans.

Staff felt well supported by the registered manager and there were regular meetings with them to ensure they were consulted and informed of changes.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people's health and wellbeing were not always fully assessed and reviewed. This meant that lessons were not always learnt when things went wrong to avoid repetition. Staff did not always recognise and report concerns to protect people from harm. People were supported to take their medicines safely and there were systems in place to store them securely. There were sufficient staff to ensure that people were supported safely. Safe recruitment procedures had been followed when employing new staff. Infection control procedures were embedded.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to work with people effectively. They understood how to support people to make decisions about their care. If they did not have capacity to do this, then assessments were completed to ensure decisions were made in the person's best interest. People were supported to maintain a balanced diet and to access healthcare when required. This was done through close collaboration with other professionals. The environment was designed to meet people's needs.

Is the service caring?

Good

The service was caring.

Staff had developed caring, respectful relationships with the people they supported. People were supported to make choices about their care and their privacy and dignity were respected and upheld. If they could not communicate their choices independent advocates were provided. Relatives and friends were welcomed to visit freely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care and engagement based on their personal preferences and choices. People did receive good care at the end of their lives. Complaints were investigated and responded to in line with their procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not always respond to concerns thoroughly too ensure they improved the quality of people's service. People knew the registered manager well and reported that they were approachable. The staff team felt well supported and understood their responsibilities.

Newlands House - Care Home with Nursing Physical Disabilities

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service was injured. The information shared with CQC about the incident indicated potential concerns about the management of risk of injury from hazards. This inspection examined those risks.

This inspection took place on 27 September 2018 and was unannounced. The inspection was completed by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information that was shared with us by commissioners of the service to assist us to plan our inspection. We also used information we held about the home which included notifications that they sent us. The provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this to assist us to plan and to make our judgement.

We used a range of different methods to help us understand people's experiences. We spoke with seven people who lived at the home about their experience of the care and support they received. People who lived at the home had variable verbal communication and some people were living with dementia. Therefore, we observed the interaction between people and the staff who supported them in communal

areas throughout the inspection visit. We also spoke with one relative to gain their feedback.

We spoke with the registered manager, the deputy manager, two nurses, two activities staff, and four care staff. We received feedback from two health and social care professionals prior to the inspection visit. We reviewed care plans for five people to check they were accurate and up to date. We also looked at medicines administration records for seven people. We reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included audits and quality checks for medicines management, accidents and incidents, complaints and the service development plan. We asked the registered manager to send us additional audits related to staff training and reviewing call bells after the inspection visit and they did so in the timeframe agreed. They also sent us an investigation report as requested.

Requires Improvement

Is the service safe?

Our findings

Risk to people's health and wellbeing were not always assessed and mitigated to ensure that people were protected from harm. One person described an accident they had. They explained about a hazard that was in place when they had the accident. This was not there to protect them from harm and it prevented them from entering their own room. They told us they had raised their dissatisfaction with this to staff previously. On the day of the accident they had attempted to bypass the hazard and this had caused a serious incident; the person had required emergency medical treatment. The hazard had not been assessed by the provider to consider the potential harm to people who lived at the home. There was no risk assessment in place. When we spoke with a member of staff about this incident they said, "That accident was entirely [Person's name's] fault." This reinforced to us that the potential risk was not considered from the person's perspective.

We reviewed other incidents and accidents and saw that it was not always clear what had caused them to occur. For example, one person was found unsupervised in a position which put them at risk of choking on two occasions. It was unclear how these incidents had occurred or what action had been taken to reduce the risk. In addition, another person had been involved in two accidents in June 2018 which involved harm to other people who lived at the home. The action taken had been to remind the person to sit differently in their wheelchair to control it better. However, there were two more accidents recorded in July 2018; again, involving other people. This demonstrated to us that the provider had not taken adequate action to assess the risk to people and to put measures in place to avoid recurrence.

This is a breach in Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

When we spoke with the registered manager about these incidents and others they recognised that some of them could have been considered as potential safeguarding investigations because of the risk of harm to other people. Staff were able to tell us about their responsibilities to protect people. For example, one member of staff said, "Our safeguarding training is updated every year. I would go straight to a senior member of staff or a nurse if I had any concerns and I am confident they would follow them up." However, they did not necessarily recognise some of the incidents we described as potential safeguarding concerns. Therefore, although there were systems in place to review incidents and accidents we were not assured that they were always fully reviewed or consideration given to why the initial risk was not fully assessed. This also meant that lessons from where things went wrong could not always be learnt.

Other risks to people's health and wellbeing had been assessed and there were actions in place to reduce the risk. One person we spoke with said, "I feel safe when the staff use the hoist, there are always two staff then." Some people could have sore skin and equipment was used to reduce the risk which included pressure cushions, specialised mattresses and regular support to move so that pressure was relieved from specific areas.

At our last inspection we found that medicines management required improvement to reduce the risks associated with them. At this inspection we found those improvements had been made. One person told us,

"The nurses look after my medication and I am quite happy for them to do it." In the PIR the provider told us, 'A new electronic medication system was introduced this year. This has removed paper medication administration records and reduced the risk of medication administration errors.' We spoke with staff about this. One member of staff said, "The electronic system took a little while to get used to. However, now we like it because it reduces the risk and its clearer to see what people have taken." The registered manager confirmed this. They said, "We were one of the pilots for this and at the start there were some errors. However, now it is in place it is good for oversight; for example, I can look on the computer and see if all medicines have been administered." Staff told us they had received training in the new system and that there was also telephone support available from pharmacists. They also told us about the procedures they had in place to support new or temporary agency staff. One member of staff said, "If agency staff are not familiar with the system we ask them to come in prior to working on shift so that we can go through it with them." We checked the medicines and saw that there was guidance in place for those that were prescribed for people to take 'as required'. Medicines were recorded when they were administered and a review of stock was also maintained to ensure that it cross referenced the records and that there were enough stored for people.

The home was clean and odour free and there were infection control checks in place. There was a five star rating from the food standards agency, which is the highest possible rating. The food standards agency is responsible for protecting public health in relation to food. When we spoke with staff they understood their responsibilities to protect people from infection and we saw that protective equipment such as gloves and aprons was readily available.

There were enough staff to ensure that people's needs were met safely. However, people we spoke with gave us mixed feedback. For example, one person said, "I have to wait a long time when I press the buzzer. They need more staff." We spoke with the registered manager about people's feedback. They told us that they had recently introduced additional staffing from 10am until 6pm to assist with busy periods of the day; for example, when people needed support to eat at mealtimes. We saw that each person at the home had an individual assessment and for some people this meant they were provided with one to one staffing to support their needs. However, the registered manager stated that other people's needs had changed and they were asking for those people to be re-assessed. They were reviewing waiting times when people used the call bell and reported that there had recently been a reduction in the amount of time people waited.

The provider followed safe recruitment procedures to ensure that staff were safe to work with people. One member of staff told us, "I had to wait for all my checks to come back before I started. I showed them my identification, they did police checks and asked for references from my managers at my last work."

Good

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection, we recommended that the provider should ensure that all decisions made in people's best interest should demonstrate what the person's current capacity to make that decision was. At this inspection we saw that this had been implemented and there were thorough assessments in place. For example, the assessment considered one person's ability to make decisions about the treatment they wanted at the end of their lives. This had been re-visited with relatives who held legal responsibility to do so as their health had deteriorated. Other restrictions which had been put in place to protect people, had also been considered under MCA; for example, bed rails and lap restraints.

DoLS authorisations were in place when people did have restrictions in place that they could not consent to and we saw further applications were in process. Conditions on DoLS were understood by staff and actions were in place to ensure they were met.

Care and support was planned and delivered in line with current legislation and best practice guidance. Staff understood people's assessments about their needs and were given guidance to assist them to meet them. For example, one person had a specific intervention to control their condition and there was national guidance available for staff in their care plan to explain this. There was information about people's conditions and several staff we spoke with referred to folders of information they could access in the office. In the PIR the provider told us, 'Staff have access to a Monthly News Brief produced by The Head of Clinical Excellence for the organisation.' One of the staff told us, "We are well supported and encouraged to develop expertise; for example, one of our team are representing the organisation at a conference to share learning on tissue viability and how we support people to protect their skin."

Staff who were skilled and knowledgeable to support people effectively. One person we spoke with said, "The staff are always training. They help me how I expect them to help me." Another person told us, "It's a good place to live because of the people that work here. They are well trained and kind." Staff confirmed that they received regular training and supervision to be able to do their job well. One member of staff told us about the support they received when they were first employed. They said they had the opportunity to do some on line training as well as shadow experienced staff. Other staff who were in a supervisory role told us that they had had the opportunity to do training in management skills. Another member of staff told us that they had attended regular updates from the provider. They said they also valued local training provided by other professionals and they found the input from the Speech and Language therapist informative, in understanding how to provide adapted meals and drinks for people to reduce the risk of choking.

People's healthcare needs were met to ensure their wellbeing. People we spoke with told us they had access to a range of health services such as physiotherapists, opticians, and nurses. There was also a physiotherapy team employed by the provider and people told us they had support from them several times a week. One person said, "They help me to bed if I am poorly and the doctor comes." There was a weekly surgery with the GP and regular contact with other professionals. Referrals were made for advice when people's needs changed. This demonstrated to us that the staff team worked effectively across organisations to ensure that people's needs were met.

People were supported to have enough to eat and drink. One person told us, "The food is fine and they give me something else if I don't like the food." We saw the menu choices were written on a board and people chose their food from this. One person chose their meal and asked for it to be reserved for later and we saw that this was accommodated. When people required support, they were offered it patiently and with respect. Some people had aid and adaptations to assist them to eat more independently such as adapted cutlery or plate guards.

Some people who lived at the home received their nutrition through a percutaneous endoscopic gastrostomy (PEG). A PEG refers to a flexible feeding tube which is placed through the abdominal wall and into the stomach. There was guidance in place to ensure that people received food and drinks in a safe way and we saw that staff followed this. At mealtimes people who no longer ate food were occupied elsewhere in the building so that they would not find it distressing.

Staff were knowledgeable about specialist diets that people required and food was prepared to meet their assessed needs. People were monitored and if they were losing or gaining weight, they were supported with their diet. Staff told us that they kept records of people's meals when they were at risk and we saw that these were completed.

The environment was accessible and met people's needs. For example, the dining tables could be raised or lowered to the correct height for people to sit at to enjoy their meal. There was a separate part of the building for activities provision and this included an IT suite. There was a large courtyard that people could access independently and areas had been designed to have shade as well as seating areas.

Good

Is the service caring?

Our findings

People had caring, kind and supportive relationships with the staff who supported them. One person told us, "Staff are kind and treat me with dignity. They do listen to me." Another person said, "The staff are kind." We saw warm interactions between staff and the people they supported laughing together and giving people hugs. This included with people who were not able to communicate verbally. We saw staff asking people questions and understanding their nonverbal communication; for example, one person looked away when they did not want something and smiled and vocalised when they did. Staff and the registered manager were aware of local advocacy support available and people living at the service had used it. Advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes.

There were conversations during the day which showed that care staff knew about people's lives and their family situations. For example, we heard one member of staff ask one person about their partner and family. People were supported to maintain relationships when they moved into the home and explained to us how staff ensured they had privacy to do so. Some people had different cultural backgrounds to the majority of the people who lived at the home and staff told us how they had explored how they could meet the persons care and support needs in line with this.

People were involved in making choices about their care. One person told us, "I can get up and go to bed when I want to. I can make my own decisions about what I do." We saw that people were asked what they wanted to do and that this was provided; for example, when people requested staff support so that they could rest on their bed.

People were encouraged to be as independent as possible. For example, some people chose to smoke cigarettes. The provider had ensured that an outside area was available for them to do this. We observed that some of the people used adaptations so that they could continue to smoke independently; for example, a devise which meant one person smoked through a pipe attached to the cigarette.

Dignity and privacy were upheld for people to ensure that their rights were respected. There was a separate room for people to receive assistance from nursing staff privately; for example, to have their nutrition attached through the PEG. If people needed personal support they were assisted to go to their bedrooms or bathrooms so that it was completed in privacy.

There were celebrations of special occasions; for example, birthday parties. Photographs of these and events at the home such as summer fetes were on the walls for people to enjoy. Relatives and friends were welcome to visit freely and we saw friendly interaction with staff when they did. One person told us, "My family can visit me when they want to." Another person said, "My relative visits me every day." In the PIR the provider told us that people often spent time away from the home staying with their families and we found that this was the case on the day of our inspection visit.

Requires Improvement

Is the service responsive?

Our findings

Some people did not always receive care based on their preferences or wishes. One person told us, "Some of the decisions made are about policy and not individual care." For example, they told us they had never had a bath in the home because the hot water was set at a temperature which they would not find hot enough for comfortable bathing. They said, "I have been told that it is a set temperature following the provider's guidance and cannot be changed." They also told us how a request for a different way to be moved had been negotiated for over one year. Although this practise had been put in place now they were frustrated at the amount of time it had taken. Again, the explanation they had been given was that it was against provider policy. They told us that they felt that decisions were not always made on an individual level. They had been able to use a key to access an outdoor area but as someone else had left the door unlocked the key was now not available for anyone who lived at the home to use and they had to request staff support. We spoke with the registered manager about these and other issues raised and they were not aware that this was the feedback given to the person for these incidents.

Some people who lived at the home were not able to verbally communicate their wishes. Some of those people were engaged during the inspection visit and participated in organised activities. However, others spent large amounts of time in front of a television with little interaction from staff other than to provide care or nursing support. They were not asked what their preferences were for how they spent the day and as they were unable to move themselves independently, they remained in the same position. This showed us that not every individual's preferences were considered or planned for throughout the day, to ensure they could have some stimulation and engagement.

People we spoke with told us of activities they liked to engage in outside of the home. For example, one person said, "I go out to the cinema, I like action films the best. I have to ask to go to the cinema as I need one to one staffing and I have six hours a week with my Key Worker." Staff we spoke with told us that other people did not go out of the home often. One member of staff said about one individual, "No, they don't have outings other than hospital appointments." Some people did not have one to one staffing in place to ensure they were able to go out and enjoy activities away from the home. In the PIR the provider told us, 'We are increasing the Midas trainers [a driving course to be able to drive community transport] to enable people to attend social activities in the community and beyond. We are also actively training both staff and volunteers to enable people who would otherwise not be able to go out, to access outings and holidays.' On the day of our inspection people did not go out from the home unless they had arrangements with other organisations; for example, to go to college. In addition, one person told us that they liked to use the IT suite but there were restricted times that this was available dependent on volunteer availability. This demonstrated to us that people were not always able to engage in activities outside of the structured ones to meet their requirements.

Care plans did not always give clear consistent advice. One person had a sleep system which consisted of using aids when in bed to support their posture and protect their skin. When we asked the member of staff who was supporting the person how they knew the position to put them in, they told us that another member of staff had shown them how to use it and they had also spoken with the person's relative. They

also said they referred to photographs on an instruction sheet. When we reviewed this, we found that it was a generic instruction leaflet from the manufacturer. Other people at the home had a similar system in place and we found that their guidance had photos of the person using the system which was much clearer. When we spoke with the registered manager they stated that they thought there should be a similar version in place for the first person, but this was not provided on the day of the inspection visit. This placed the person at risk of receiving incorrect support which could cause harm to them.

Some daily monitoring records were not fully completed to ensure that people had the care they were assessed to need. For example, some people had nutrition charts in place to ensure that they had enough to eat each day. We found that they had not been fully completed; in the previous four days, one person's had not been completed on one day and two days were only partially completed. Similarly, fluid charts were not fully completed to ensure people had drank all the fluids they needed in one day. One person was recorded as drinking 1200ml on one day, 700ml on another and 850ml on a third. It was unclear how much they needed to drink or if any action was taken when they did not meet their target. Therefore, the systems which were implemented to ensure that people's health and wellbeing were monitored to ensure they received the care they needed were not always effectively applied.

Some people who lived at the home had disabilities and sensory impairments. The provider had not complied with the Accessible Information Standard (AIS). This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand. Information had not been shared in an accessible way for people who lived at the home. When we spoke with the registered manager they could share the provider's policy with us but were not able to explain how they had implemented it.

This is a breach in Regulation 9 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

There were organised activities provided by a separate team in a discrete area of the home. We saw some people enjoying these and other people told us they often participated as well. One person said, "I enjoy the activities, particularly the quizzes."

There was empathetic care and support provided when people were at the end of their life. We spoke with the relative of a person who had recently died at the home. They told us, "They were brilliant. The nurses were supported to understand palliative care so that we could keep my relative in their home. They looked after me as well and I had a bed here. They helped me all the way through and we had the funeral and wake here. It was marvellous. The registered manager was amazing and organised it all." One member of staff told us, "When that person was diagnosed as terminally ill we didn't have a plan in place to describe their wishes. We had support from a local professional to put the plan and systems in place. We are now implementing 'Advance care planning' with other people so that we can ensure we plan for their preferences. Some staff have received specialised training and we have more planned in the near future." We were told of one person who may be coming to the end of their life soon and saw that this plan was in progress.

There was a complaints procedure in place that people were confident to use when needed. One person told us, "I would speak with the nurses or the registered manager if I needed to." When the provider did receive complaints, we saw that they were responded to in line with their procedure. We spoke with the registered manager about the actions they had taken as a consequence; for example, clarifying financial arrangements.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections we found that the systems in place to review and monitor the quality of the service were not always sufficient to drive improvement. At this inspection we found that improvements were still required.

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.

We discussed concerns which had been raised with us prior to our inspection, about the skills and qualifications of some staff. The registered manager told us what actions they had taken. Although some safeguards had been put in place they were not sufficient to ensure that the provider was confident in the staff's competence. They were waiting for an external organisation's assessment rather than fully reviewing the situation themselves and the staff had continued in their previous role with no increase in supervision.

When we discussed safety incidents which had occurred in the home with the registered manager, we were not satisfied that the seriousness of the situation had been fully investigated. The investigation had been completed by the registered manager and they had provided a report to the provider, but no other interviews or provider visits had followed. This did not assure us that the full circumstances around the situation had been satisfactory reviewed to ensure that they were not repeated.
Systems and audits had been implemented to improve the quality of the service people received. The registered manager had worked on an action plan with the local authority earlier in the year to improve how care plans were reviewed and to more closely monitor staff training and supervision and we saw that these systems were now in place and were effective. The nursing team and the deputy manager completed clinical audits and maintained clear records on people's health needs. However, whether people were receiving care that met their preferences was not always prioritised. For example, staff raised concerns with us about one person's preferences and choices and when we raised this with the registered manager they were aware of them. However, no action had been taken to review the care. The system which was in place to monitor whether staffing levels were appropriate reviewed call bell usage. However, a significant number of people in the home were unable to use the call bell and their experience had not been considered.

The service has been rated as requires improvement at the past two inspections and at this inspection we found they were in breach of regulations and the overall rating for this service is Requires Improvement again. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive.

We will ask the provider to give us information about how they plan to improve the quality and safety of the service and the experience of people using it under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will also be meeting with the provider to review what changes will be made to ensure that outcomes for people who use the service improve.

People told us that the manager was approachable and that they liked them. One person said, "They are a good boss and they try to look into things as best they can. I enjoy the resident's meetings because they give me a chance to say what I want and that's important. I can always talk to the manager; their door is always open." We observed the residents meeting which took place on the day of the inspection which thirteen people who lived at the home attended. They discussed fundraising events, Christmas activities and renovations planned for the home. It was a relaxed and interactive meeting and we saw that the registered manager ensured that everybody was able to contribute in their communication style.

Staff were well supported in their role and felt that the registered manager was helpful. One member of staff told us, "We work well as a team and we are well supported." Regular meetings took place and we reviewed the records for them and saw that the registered manager informed staff about developments in the home and sought their opinion; for example, they discussed use of agency staff and updated staff on the recruitment of new staff.

The manager ensured that we received notifications of important events in line with their registration. This meant that we could review that appropriate action was taken. We also ask the provider to display their latest CQC inspection report at the home and on their website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always received personalised care which was based on their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always received safe care and treatment.