Care Quality Commission

Cherrytree Care Limited

Cherrytree Residential Home

Inspection report

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Leicestershire
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on the 23 February 2015 and was unannounced.

At the last inspection on 9 January 2014 we found the provider met the requirements of the regulations that we looked at.

Cherrytree Residential Home is a care home for up to 40 people and provides care and support to people with needs associated with age and physical disabilities, and people living with dementia. On the day of our inspection 32 people were living at the home.

Cherrytree Residential Home is required to have 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. At the time of the inspection a registered manager was in post.

People and their relatives told us that they had no concerns about safety. People told us that they received

Summary of findings

their medicines safely and at the right time. Some relatives thought the staffing levels could have been better to enable staff to have had more time to spend with people. The manager assessed the needs of people and this determined the staffing levels required.

Staff were aware of the safeguarding procedures in place and of their responsibility to protect people and how to report concerns. We found people received their medicines safely but identified some concerns with the management of medicines.

People and their relatives told us that they were supported to maintain their health by having access to healthcare professionals when they needed to. People were positive about the meal choices and said they received sufficient to eat and drink. People had their dietary and nutritional needs assessed and planned for. Referrals were made to healthcare professionals on the whole in a timely manner.

Staff received an appropriate induction and ongoing training. However, we identified that staff had not completed all the training that the manager had identified as required. Staff did not receive regular opportunities to discuss and review their practice and development needs with their line manager.

Some people did not have the mental capacity to make certain decisions about their care and treatment. The manager had not adhered to the Mental Capacity Act 2005 (MCA) Code of Practice. Staff also lacked understanding of this and the majority of staff had not received MCA training. The manager demonstrated they were aware of the Deprivation of Liberty Safeguards and had acted appropriately when required.

People and their relatives were positive about the approach of staff and said staff were kind and caring. We found staff treated people with dignity and respect and that consent was sought before care and support was provided.

People and their relatives told us that care was based on their routines and preferences and what were important to them. However, we found information about how to meet people's needs lacked some of the key information that staff needed to support people effectively.

People and their relatives received opportunities to share their views and experience of the service. Social activities were provided. The information available to people about independent advocacy services was out of date. Whilst the provider's complaints procedure was on display its position was not accessible.

We found some concerns with people's plans of care and associated risk assessments. We saw examples where people had specific health conditions that did not have a plan of care advising staff of their needs and how to meet those needs. We also saw examples of plans of care that lacked detailed information and guidance for staff. Care records had not always been fully recorded.

The quality assurance systems in place had failed to identify some of the concerns we found.

The provider had identified some concerns with the safety of the environment but risk assessments for these had not been completed.

Staff had opportunities to be involved in decisions and discussions about how the service was provided. Staff meetings were held and there were communication systems in place including handover meetings to discuss people's needs on a daily basis.

We have made a recommendation about the management of complaints.

We found the service was in breach of two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Plus one breach of (Registrations) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us that they felt safe. Staff were aware of how to protect people from avoidable harm and the actions to take if they had any concerns. People received their medicines safely but the storage of medicines required action to maintain safety.

The risk management plans for people with needs associated with their behaviour, lacked detailed information including how to reduce the likelihood of incidents occurring. Some concerns were found with the safety of the environment.

People said that staff had limited time available to spend with them and this concerned them. This reflected what staff told us. The manager assessed people's needs to identify the staffing levels required.

Requires Improvement

Is the service effective?
The service was not consistently effective

People told us that they found staff to be skilled and experienced. Staff received an induction and on-going training, but training the manager had identified the staff required had not been completed. Staff did not receive appropriate opportunities to review their practice and development needs.

The Mental Capacity Act 2005 Code of Practice had not been adhered to. People who lacked mental capacity had not been assessed and best interest decisions had been made without following due process.

People told us that they were supported to access healthcare professionals when required. People had their dietary and nutritional needs assessed and planned for.

Requires Improvement

Is the service caring?
The service was caring

People spoke positively about the staff. We observed some good examples of care and compassion provided by staff that showed people were treated with dignity and respect.

People told us they were supported with their religious and spiritual needs and that they had been consulted about their needs, preferences and routines.

The information about independent advocacy services was out of date. Communication with regard to meal choices was not clear.

Good

Is the service responsive?
The service was not consistently responsive.

Requires Improvement

Summary of findings

People told us that they were given choices about their routines and this was respected and acted upon.

People told us that they were aware of the complaints procedure and that they felt confident to raise any concerns or make a complaint if required.

Staff lacked detailed information about how to respond to people's individual and assessed needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

People that used the service including staff spoke positively about the leadership of the service.

People and their relatives received opportunities to feedback to the provider their views and experience about the service and said that they felt listened to.

The provider had quality assurance checks in place but these had not identified the concerns that we found with regard to quality and safety.

The manager had not adhered to the requirements of their registration; they had not always notified us of significant events as required.

Cherrytree Residential 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 was 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 23 February 2015 and was unannounced. The inspection was completed by two inspectors and an Expert-by-Experience. The Expert-by-Experience had personal experience of caring for someone using health and care services.

We reviewed information the provider had sent us, such as safeguarding notifications, these are made for serious incidents which the provider must inform us about. We also contacted the local authority who had a contract with the provider for their feedback about the service.

On the day of our inspection we spoke with six people who used the service and three visiting relatives. We also used observation to understand people's experience of the care and treatment they received. We spoke with the registered manager, the cook, and five care staff including senior care staff.

We also spoke with a visiting community nurse, two visiting community mental health nurses and received feedback from the GP. We looked at the care records of four people who used the service and other documentation about how the home was managed. This included policies and procedures, records of staff training and records associated with quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt staff provided a safe environment, and that the care and treatment they received was provided safely. Relatives we spoke with also said they were confident that their family member was safe and well-cared for.

Staff were aware of their responsibilities and the action required to protect people from abuse and avoidable harm and knew about the whistleblowing policy. Staff told us they had received training in safeguarding and records confirmed this. One care worker told us they had identified and reported safeguarding incidents before to the manager.

Some people had behavioural needs that put themselves and others at risk. We looked at these risk plans and found detailed information about known and possible triggers that could affect the person's mood and behaviour were missing. Guidance was more about how staff should react to a situation rather than being proactive to reduce the likelihood of behaviours occurring. We found that there had been three recent safeguarding incidents regarding a person's behaviour that had affected other people using the service. The lack of information and guidance for staff may have been a contributing factor to these incidents occurring.

We found further examples where people's individual risk plans lacked information and guidance for staff on the action required to reduce and manage risks. For example, a person had a catheter in place but a plan of care or risk assessment was not available for staff. Whilst staff were able to give a basic account of how to provide care, they did not have written information or guidance of what the risks were for the person and the action required if concerns were identified. We discussed this with the manager who could not give a reason why this information was not available and agreed that this information was required.

People and their relatives did not raise any concerns with us about the safety of the environment or equipment available.

We found that the manager had plans in place that checked the safety of the environment and equipment. People who required specific equipment to meet their needs had this available to them.

All the radiators on the ground floor were very hot to touch. The manager told us that a new boiler had been fitted in November 2014 and this had affected the temperature of the radiators. The manager also said they had ordered radiator covers which were to be supplied and fitted in March 2015. We saw notices were on display warning people that the water temperature was very hot. We saw the water treatment recording book for January 2015, stated the water was a 'very high temperature' and all but one of the water taps were above 40°C and 21 over 70°C. The Management of Health and Safety at Work Regulations 1999 and the Provision and Use of Work Equipment Regulations 1998 (PUWER) both stated in the Health and Safety Executive guidance for care homes, advise that the temperature of the water discharged should not be greater than 44°C.

The manager told us that thermostatic valves were due to be fitted. However, we were concerned that the manager had not completed a risk assessment to ensure that suitable and sufficient controls had been fully considered to ensure people's safety during the interim period before the work on the radiators and hot water had been completed.

People told us on the whole staffing levels were sufficient, however, one person said, "It [staffing] varies, if staff are off sick there is less." Some people raised concerns that staff did not have time to spend with people. One person said, "I would like them [staff] to chat to me as I feel stranded."

Throughout our inspection we noted that the call bells were generally answered in a timely manner. One person told us, "They [staff] respond well to call bells."

Staff told us on the whole staffing levels were sufficient. One care worker said," Nine times out of ten we have enough staff, the only issues are if someone goes sick. The manager will always help if she is in." Another care worker old us, "The majority of the time there is enough staff. Sometime it would be nice to have some extra time to spend with the residents." Several staff said that in addition to their caring role they had to carry out laundry and some cleaning tasks and that this limited the time they had to spend with people. We observed staff carrying out these tasks.

We found the staff team's skills; competencies and experience were considered when staff were deployed. For example, the senior care staff had appropriate experience

Requires Improvement

Is the service safe?

and skills to delegate and instruct other staff. On the day of our inspection we observed there to be sufficient staff available to meet people's needs and keep them safe. However, we observed there was a general lack of staff interaction of sitting and spending time with people whilst we were there.

The manager had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels. The manager told us they regularly reviewed people's needs to ensure that sufficient staff were available. The manager gave an example of how they had deployed staff according to the needs of people. For example, two staff started work an hour earlier than the rest of the morning staff team, it had been identified that people were requesting to get up early and additional staff were required to support people.

Staff employed at the service had relevant pre-employment checks before they commenced work. This included a check with the 'Disclosure and Baring Service' (DBS) which check criminal records and staff suitability to work with people who use care services.

People and their relatives were confident they were supported with their medicines safely and appropriately. Two people told us their medicines were given on time. People also said that extra pain relief was given if required. One person said, "You just have to ask."

We observed the administration of the lunchtime medicines by a senior care worker and found this was completed safely and appropriately according to people's individual needs. A person asked what their medicine was and an explanation was given.

We found some concerns with the management of medicines. This included the disposal of medicines that were no longer required. Additionally, the medicine room was required to have the temperature checked to ensure medicines were stored correctly. We found some gaps in the temperature checks that had not been picked up by the person responsible for completing the audits. We also found the system for receiving medicines and the checks for stock control was not sufficiently robust enough to ensure stock was adequate and monitored. Whilst people had not been directly affected, the systems in place required a review to ensure people's continued safety.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) is legislation that protects people who are not able to consent to their care and treatment. It also ensures people's liberty and freedom is no unlawfully restricted. We found concerns that showed this legislation had not been adhered to by the manager.

Whilst there was no person present who had an authorisation in place that restricted them of their liberty, the manager gave an example of where they had recently submitted an application to the supervisory body. The manager also told us that they had spoken to the supervisory body for further guidance due to the changes with the DoLS legislation that were made in 2014.

Some people who used the service were not able to make certain decisions about their care due to living with dementia. A member of the management team told us that 10 people living with dementia had a sensor mat placed by their bed to alert staff when the person got up. However, there was no evidence that the use of this was the least restrictive option. There was no record to show how this decision had been made such as a consultation with a relative if appropriate or health care professionals. We found that people had not received an assessment of their mental capacity and best interest decisions were made with no regard to the MCA Code of Practice.

The manager told us there was a MCA and DoLS policy and procedure but they could not locate this. Four out of the five care staff we spoke with told us they had not received training on MCA and DoLS, and were unable to tell us what this legislation meant to people who used the service. The staff training matrix showed that the majority of staff, 26 out of 39 had not received this training. We found the provider did not have guidance or procedures about the arrangements and action staff should take where they had concerns about a person's mental capacity to make a decision about their care.

We found that the registered person had not protected people against the risk receiving care and treatment without consent. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives made positive comments about the skill and experience of care staff. One person told us, "Staff are well trained", and this reflected other comments made.

Staff told us about their experience of the induction they received when they commenced work at Cherrytree Residential Home. This included training and an opportunity to shadow other staff to familiarise themselves with people's routines and needs before they provided care independently. One care worker said, "I love working here. When I started I received training and shadowed other staff. We work well together." Staff told us that they received regular opportunities to attend training. One care worker said, "Training is really good here."

We looked at the staff training matrix that the manager had developed based on people's care needs. We noted that out of 39 staff none had received training on pressure area care and only seven staff had received training in diabetes. This was a concern as people that lived at the service were living with or were at risk of these conditions had these needs. Whilst no issues or concerns had been identified with these people's care, the lack of training meant staff's knowledge and awareness was not based on best practice guidance and latest research. The manager told us that they were in the process of arranging diabetes and pressure area care training. They said that they would forward these training dates to us after our inspection; however, this information was not forwarded to us. Staff had not received training that the manager had identified was required for the people living at Cherrytree Residential Home.

Staff told us that they had not received regular opportunities to review their practice and development needs, and could not recall the last time they had, but said they felt supported. One care worker said, "I feel I can raise any issues with the manager who is always available." Another care worker told us, "We don't have regular supervision but I would welcome this."

The manager said that they were aware that staff supervision and appraisal meetings were required and they had developed a plan of when staff would have these meetings. This plan was not available, the manager said they would forward this to us after the inspection but we did not receive this information. Whilst staff said they felt supported there was no system for staff to have their performance reviewed.

Requires Improvement

Is the service effective?

People and their relatives spoke positively about the food choices available. One person told us, "I like the food choice, the food is good." Another person said, "If you want something different, then they [the cooks] do it."

We observed lunchtime and found staff were well organised. Some people required assistance or encouragement with their meals and staff supported people appropriately and respectfully whilst promoting independence.

Some people had specific dietary and nutritional needs. We found both the cook and care staff were aware of people's needs and how to support them. Staff had worked with health professionals such as a dietician when concerns had been identified about weight loss. Where recommendations from health professionals had been made, we saw examples these had been included in people's plans of care. We saw examples where the dietician had recommended food supplements for weight gain or for food to be provided in a specific way such as pureed and this was recorded to inform staff.

People were asked about their food choices and this was acted upon. For example, we saw a 'resident meeting' record dated October 2014. This showed people had asked for specific food choices such as cheese and biscuits. We observed that cheese and biscuits were included in the choice of puddings on the day of our inspection.

People and their relatives told us that the GP and community nurse visited regularly. A relative said that the home had requested a visit from the GP due to a health issue with their family member and that this was dealt with promptly.

We spoke with a community nurse who advised that on the whole staff followed their recommendations. Additionally they said that they found senior staff supportive and knowledgeable about people's needs.

We observed a staff handover and found staff discussed each person detailing their progress that day and any issues to be aware of. We noted a good level of detail was given for those people who had higher needs.

People were supported to access ongoing healthcare support. We saw visits from or to healthcare professionals were recorded.

Good

Is the service caring?

Our findings

People and their relatives made positive comments about the approach of staff. One person told us, “Staff are very nice. All very good and helpful.” Another person described care staff as, “Definitely caring and give support.” These positive responses were also reiterated by the relatives we spoke with. One relative described care staff as “1st class” whilst another relative said, “I feel it would be difficult to find anywhere else that is as caring.”

Staff were aware of people’s preferences and personal histories. The lunchtime observation found that people were relaxed, the atmosphere was calm and people interacted with each other and staff.

People were supported by staff at their own preferred pace. For example when they were being supported with their mobility needs staff did not rush them and gave them their full attention. We observed staff used peoples’ preferred names and showed good communication skills such as gaining eye contact, using nonverbal cues and speaking at an appropriate pace and in a caring and attentive manner. Staff offered people choices throughout the day including what they wanted to drink and where they wanted to sit. We also saw that staff gained people’s consent before care was provided.

We noted that the menu was displayed in written form and next to it were photographs of meals that did not relate to the menu. Whilst the manager said this was to promote choice the photographs did not relate to the food choices on the menu so therefore was misleading. We also noted that people were asked to make a choice of what meal they wanted the day before they received it. We further noted that when staff were serving people’s meals they did not remind people what it was they had chosen. Some people were living with dementia and may have found it difficult to remember what food choices they had made.

Staff spoke positively about their work. One care worker told us, “It’s a very welcoming home, staff go the extra mile.” Whilst another care worker said, “We have a right laugh with the residents; we get the music on and start dancing.”

People and their relatives told us that they were involved in discussions and decisions about the care and treatment they received. People told us they were aware that plans of care were in place. One person said, “The home sit down with both residents and relatives to discuss the care plan.” Another person said that they had recently been involved in a meeting about their needs.

People told us staff respected their privacy and dignity when they supported them. We saw staff knocked on people’s doors before entering people’s rooms. We saw there was one shared room that had a portable screen used to protect people’s dignity.

People could be confident that their personal details were protected by staff. Confidential information about people was kept securely. This ensured that people such as visitors and other people who used the service could not gain access to people’s private information without staff being present.

Information about independent advocacy support was available in the reception area. This mentioned that there were further information in leaflets but these were not available. We also noted that the advocacy information was out of date. We raised this with the manager who said they would ensure appropriate information was available for people.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to them moving into the service. The assessment process included the views of people who were considering using the service, their relatives and relevant health and social care professionals, where appropriate.

A relative told us that they had been involved in the assessment of their relative's needs and this information was used to develop plans of care. They said, "It's too early to comment on how responsive the service is but so far so good."

People said that they received care and treatment that met their needs and respected their preferred routines and what was important to them. However, we found the information included in people's plans of care about people's preferences and routines were limited. For example, it was unclear what people's likes and dislikes were and what their preferred routines were. This was concerning because some people living at Cherrytree Residential Home had communication needs and were totally reliant on care staff to know their individual needs and how to meet these. The manager told us that they were planning to introduce a new document that they referred to as 'All About Me' that would include more person centred information about people's needs. The manager added that staff handover meetings were used as a method of exchanging information about people's needs. However, they said this was more about changes in people's health and wellbeing and less about people's preferred routines.

People told us that there was a choice of daily activities that they could participate in if they wished. One person said, "If you don't want to do it that is ok." People told us that they enjoyed playing cards and dominoes. We saw information displayed that informed people that daily entertainment was available from 10.15am until 3pm. This included a reminder that scrabble and jigsaws were also available and monthly visits from local places of worship.

A relative told us that they had mentioned to the activity staff how much their family member enjoyed walks and fresh air. They said the activity staff supported their family member to go on short walks which they greatly appreciated.

Staff told us that people received opportunities to socialise and activities were provided. Additionally, they said that people had choice of when they got up and went to bed. One care worker said, "There's always something going on for residents." Another told us, "Residents can choose when to get up."

The hairdresser was at the service on the day of our inspection. People told us how important it was to them to have the hairdresser visit. We saw this was a social event where people sat together having their hair done over a cup of tea and a chat.

We noted that the television was on but people did not appear to be watching it. In the afternoon music was playing in addition to the television being on, however, the music was loud and the television could not be heard. It was unclear if people had been given a choice of what to watch or listen to.

Some people were cared for in bed and required repositioning and their health monitored at particular intervals throughout the day. We saw from two people's written records that staff had not recorded if they had provided the care that was required. For example, one person had a movement chart that showed when they had been repositioned; this was a requirement of their skin care routine to reduce pressure sores developing. We saw the last entry on the day of our inspection recorded by staff was at 2.10am. This was not in line with their plan of care. It was therefore difficult to ascertain if staff had responded appropriately to this person's individual needs.

Whilst we were with the manager we identified that another person who was cared for in bed had their bed positioned high and bed sides were not in place. Additionally we noted that a sensor mat was on the floor by the bed. These are sometimes used for people who are at risk of falls to alert staff if the person has got up. However, the manager said that this person was not mobile and did not require a sensor mat. Additionally, they said that the bed was too high and lowered it to the height it should have been at and that the person did not require bed sides. This showed a lack of personalised care, staff had not been responsive to this person's individual needs. We discussed this with the manager who said that they would raise these issues with staff.

Requires Improvement

Is the service responsive?

People and their relatives told us that they felt confident that if they had any concerns or complaints these would be acted upon. One person said, “Any problems, they [staff] will listen to you.” A relative told us, “You tell a carer and they listen to you.”

We saw the providers complaint procedure was displayed for people, their relatives and visitors. However, this was not in a good position particularly for people that used the service to be able to read it. We also noted that a suggestion box was available for people to use but no paper was provided to enable people to give their suggestions.

The manager told us that they did not have a formal process of recording complaints or concerns. Additionally, they said that they could not recall the last time a complaint or concern was made. They said, “I have an open door policy and people can come anytime and talk to me if they have any concerns.” Without a formal system in place the provider was unable to monitor concerns or complaints and the action taken by the manager to resolve any issues. Additionally, the provider was unable to identify if there were any themes or lessons to be learnt from complaints received.

We recommend that the provider seeks advice and guidance from a reputable source, about the management of and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

It is a legal responsibility and obligation required of a registered manager and provider to inform us of serious events affecting the service or people using the service. This includes safeguarding incidents and the more serious and life threatening pressure sores. Whilst the manager had notified us of deaths and serious injuries, on the day of our inspection we identified three safeguarding incidents and a person with a serious pressure sore that the manager had failed to notify us of. This meant the manager had not always adhered to the registration conditions with the Care Quality Commission.

These failures demonstrated a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009.

We found that the quality assurance systems had not always identified where improvements and actions were required to ensure quality and safety. For example, the concerns we identified with the management of medicines had not been identified before our inspection. This had left unnecessary risks to people's health and welfare.

Whilst the manager had identified in April 2014 that they needed to arrange staff supervision and appraisals this was not happening. They had similarly failed to ensure that staff had received the training that they required to meet the needs of people living in the service effectively.

Records for monitoring people's needs were not audited to ensure they were completed accurately by staff. This meant that there were unnecessary risks to peoples' care. Whilst accidents and incidents were recorded and the manager reviewed these on a regular basis for any patterns or themes, we found concerns with quality of the recording. It was not always clear of what immediate or follow up action had had been taken to ensure people's health, safety and wellbeing was met. The manager told us that they had started to review people's care files to ensure plans of care and risk assessments were up to date and reflected people's needs. We noted that nine out of 32 files had been completed. From the sample of care files we looked at there were significant concerns with the lack of detailed information about people's health conditions and needs on those which had been reviewed.

We also noted that the equipment audits in place did not include the monitoring of pressure reliving mattresses. This is important to ensure that the mattress is set appropriate to the needs of the person. Whilst the provider had identified action was required to ensure people's safety against the hot water and radiators, we were concerned that a full risk assessment had not been completed to check all risks were assessed and all appropriate action had been taken. This had left unnecessary risks to people's health and welfare.

We found that the registered person had not protected people against the risk of receiving care and treatment that was effectively assessed and monitored. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were positive about the leadership of the service. People said that they knew who the manager was. One relative told us, "The manager listens to you" and that "they are there if you need them."

Staff also spoke positively about the leadership of the service and said that they found the manager supportive. One care worker told us, "The manager is very supportive and I feel you can go to them with anything." Another care worker said, "The owner is really good, if you ask them for things residents need it's here the next day."

Regular meetings were held for people who used the service and their relatives. This gave people the opportunity to share their views about the service, raise any issues that they may have had and make suggestions as to how the service could be improved. We saw the last three meeting records, action from the previous meetings were feedback to people. This was good practice, it confirmed to people what action had been taken. People were involved and influenced how the service could be improved.

The manager told us that they had introduced a questionnaire that they sent to people and their relatives and professionals in January 2015. They told us they were waiting for people's responses and that they would then analyses the findings for any required action.

We looked at various staff meeting records the manager had arranged that had occurred within 2014. There were separate meetings for senior staff, night staff and all staff. These meetings were generally three monthly. We found the meeting records did not include action points detailing

Requires Improvement

Is the service well-led?

who was responsible with timescales or carried over to the next meeting to review if they had been completed. This meant it was difficult for the manager to assess and monitor where improvements were 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 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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment.** **The registered manager had not made suitable arrangements to obtain, and had not acted in accordance with, the consent of service users in relation to their care and treatment provided. Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.** **The registered manager did not have effective systems in place to assure the safety and quality of the service. Regulation 10 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 of the Care Quality Commission (Registrations) Regulations 9** **The registered manager had not notified the Commission of all incidents required under Regulation 18 (1) (2) (e)**