HICA

Elm Tree Court - Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Elm Tree Court provides accommodation and personal care to a maximum of 72 people who are living with dementia.

The building is single storey and purpose built. It is divided into three separate units that surround a courtyard. Each unit has individual communal areas, bedrooms and bathrooms.

This inspection took place on 27, 28 and 30 June and was unannounced. The service was last inspected May 2016 and was found to be in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Need for Consent; a requirement notice was set for the provider to comply with. Part of this inspection included checking whether the provider had taken the necessary action to comply with the requirement notice.

At the time of the inspection 72 people were living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like providers, they are 'registered persons'. Registered persons have a 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 last inspection in May 2016 we asked the provider to make improvements to way the service applied the principles of the Mental Capacity Act (MCA) and the use of Deprivation of Liberty Safeguards (DoLS) to keep people who need this level of support with their care and decision making safe; at this inspection we found the application of the principles of the MCA and DoLS was not consistent across the service. This meant people were not always protected by the use of relevant legislation and their liberty was unlawfully restricted. We found the quality monitoring of the service had not identified the issues we found during the inspection and did not ensure people received safe, compassionate care and that the service was well-led. You can see what action we have asked the provider to take at the end if this report.

We found that people's care plans did not always reflect their needs or had been up dated to demonstrate when people's needs had changed. This meant people who used the service were at risk of receiving care which was not person centred and which did not effectively met their needs. We found some low level physical interventions were used which had been not been discussed or assessed as being the least restrictive option or in the person's best interest. This meant people who used the service were exposed to the risk of harm and inappropriate care. During the inspection when we spoke to staff they told us people who used the service were up and dressed very early in the morning. An out of hours visit confirmed this, we found over 40% of the people were up and dressed at 6am. This limits people choices and does not respect their dignity. We found staff were not always deployed around the building effectively and this had an impact on the people who used the service particularly on the night shift. We have made recommendations about these issues and these can be seen in the main body of the report.

We found there were some medicine errors; these were report to the manger to rectify and monitor. This meant people were at risk of not receiving their medicines as prescribed by their GP. We found the meal time experience for some people was not conducive to them eating a good, balanced diet with support from staff. We have made recommendations about these issues and these can be seen in the main body of the report.

People were cared for by staff who had received training in how to recognise abuse and how to report this to the investigating authorities. Staff had been recruited safely.

Staff received training which equipped them to meet the needs of the people who used the service. People were supported by staff to access health care professionals when needed.

People were able to participate in a choice of activities and staff took the time to sit and talk to people and engage them in meaningful conversations. The provider had a complaints procedure which was accessible and all complaints were recorded and investigated.

People who used the service and other stakeholders were asked their views about how the service was run. Staff and people who used the service found the registered manager approachable and there was an open management style. All equipment was serviced and maintained as per manufactures recommendations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People subjected to low level physical interventions, which had not always been assessed as being in their best interests.

Staff were not deployed effectively to meet the needs of the people who used the service.

People did not always receive their medicines as prescribed by their GP.

Staff had received training in how to identify abuse and how this should be reported.

Is the service effective?

Requires Improvement

Some areas of the service were not effective.

People continued to be deprived of their liberty unlawfully.

Meals times were not conducive for people who were living with dementia and staff practise did not ensure people received a healthy diet.

Staff received training which was appropriate for their role.

People were supported to access health care professionals when required.

Is the service caring?

Requires Improvement

Some areas of the service were not caring.

People's choices were not always respected by the staff.

Staff had a good rapport with the people who used the service.

People were cared for by staff who were aware of their needs and how these should be met.

Is the service responsive?

Requires Improvement

Some areas of the service were not responsive.

Care plans did not reflect people's needs or instruct staff in how best to support the person.

Activities were provided for people who used the service.

A complaint procedure was in place and all complaints were investigated and recorded.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems in place were not effective in identifying short falls in the service and the monitoring in place did not ensure that the service was safe, effective, caring responsive and well-led.

People who used the service and others who had an interest in their welfare were consulted about how the service was run.

Equipment was maintained and fire safety systems were checked regularly.

Elm Tree Court - 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 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 27, 28 and 30 June 2017 and was unannounced. The inspection was completed by four adult social care inspectors and an expert by experience. An expert by experience is someone who has used or has experience of using this type of service.

Before the inspection, we looked at information we had received about the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The local authority safeguarding and quality teams were contacted as part of the inspection, to ask them for their views on the service. We also looked at the information we held about the provider.

We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 17 people who used the service and nine of their relatives. We observed how staff interacted with people who used the service and monitored how staff supported people, early in the morning, and throughout the day and including meal times.

We spoke with 15 staff including care staff and ancillary staff; we also spoke with the deputy manager and the registered manager.

We looked at 12 care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as incident and accident records and 15 medicine administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty (DoLS) code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the

legislation.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, staff rotas, supervision records, minutes of meetings with staff and people who used the service, safeguarding records, quality assurance audits, maintenance of equipment records, cleaning schedules and menus. We also undertook a tour of the building.

Requires Improvement

Is the service safe?

Our findings

During the inspection we interviewed staff they felt there were not enough staff on duty to meet people's needs effectively. During the inspection we observed staff practice and the deployment of staff. We found the deployment of staff was variable around the building and this impacted the way the bungalows were run. For example, at meal times we observed one bungalow to be very chaotic and staff did not always ensure people ate their meals. However, on another it was calm and well managed. During an out of hours visit we saw staff were rushed and did not have enough time to meet people's needs and 30 out of 72 people were up and dressed at 6am. We found staff had been employed on both day and nights in dual roles, for example, catering and caring staff during the day and laundry and caring staffing on nights. However, we were told by these staff they did not have time to help other care staff as intended.

We spoke with senior management and discussed our concerns about the availability of staff. Staffing levels were increased following these discussions. After the inspection the provider informed us that a night team manager was to be recruited to oversee night shifts.

We recommend that the provider seeks guidance from a reputable source regarding the deployment of its staff team to ensure people's needs are met at all times.

We found the use of low level physical interventions were used to support people with aspects of daily life to protect them and others from harm, for example, hand holding when assisting people with their personal care. We were told this was so neither the staff nor the person was harmed during the interventions. When we spoke with staff they told us they used these techniques on a daily basis. We spoke with senior staff, their knowledge on the use of these techniques was variable, they told us they were aware of some low level physical interventions but not all. For the most part the use of low level physical interventions was recorded in people's care plans and best interest meetings had been held which had been attended by health care professionals who could provide an opinion on whether this was the least restrict way to keep the person and others safe. However, we found some people were subject to low level physical interventions and could find no evidence in these people's care plans that best interest meetings had been held or an application made through the MCA process for a DoLS to support staff in their actions to ensure that all restrictions were done so legally and safely in accordance with the Mental Capacity Act.

We recommend that the provider ensures low level physical interventions are only used when they have been appropriately authorised in a best interest forum and agreed to be the least restrictive option to deliver the care required.

People we spoke with told us they felt safe at the service, one person said, "There is always someone around for me to call on." Another said, "I feel safe here the staff keep an eye on me" and "Yes of course I feel safe, the girls look after me."

Visitors we spoke with told us they felt their relatives were safe at the service, comments included; "I think mums safe, they let me know what's happening and you can go to the manager if there's any problems" and

"You have to ring the bell to be let in and they [the staff] check everyone into the building, you can't just wander in off the streets." Visitors' comments were variable about the staffing levels, they said; "I think there's plenty of staff on duty, you can always find staff when you need them" and "They [the staff] sometimes seem a bit pushed especially when one of them rings in sick."

When looked at the medicine system we found that on the whole these were well managed and administered safely, however, we found some medicines had been signed on the MAR chart as being administered but were still in the blister packs. We also found the medicines room was untidy and full of medicines which were waiting to go back to the pharmacist and senior staff found it difficult to work in this area. We saw any unused or refused medicines were returned to the pharmacist. The supplying pharmacist undertook audits of the medicines system as did the registered manager, and these had identified some errors but these had not been addressed. Records were kept of the temperature of the room the medicines were stored in and the medicine refrigeration to ensure medicines were stored at the correct temperature. It is recommended the provider implements a robust system for checking medicines which ensures all the people who use the service receive their medicines as prescribed by their GP. We have also reported upon the failure of the quality monitoring system in the well led section of this report.

Staff told us they were aware of the provider's policy on how to report abuse and they could describe this to us. They told us they would report any abuse to the registered manager and were confident they would take the appropriate action. Staff were also aware they could report any abuse or safeguarding concerns to outside agencies, for example, the local authority or the Care Quality Commission (CQC). Staff had received training in how to recognise and report abuse. They could describe to us what signs would be apparent if someone was the victim of abuse; this included low mood, depression or physical signs like unexplained bruising. Staff understood they had a duty to respect people's rights and not to discriminate on ground of race, culture, sexuality or age.

People's care plans contained assessments of areas of daily living which might pose a risk to the person; this included mobility, skin integrity, falls, nutrition and behaviours which might put the person or others at risk. The assessment described how staff were to support people and how to manage or eliminate risk as far as possible. For example, staff assisting with mobility by using lifting equipment or monitoring behaviour and redirecting people. The risk assessments were updated on a regular basis. Each person had their own specific evacuation plan and this described how staff were to support the person to leave the premises in an emergency, taking into account their level of understanding and mobility. However, we did find that staff were using some low level physical interventions which had not been included in people's care plans, this meant they could be exposed to risk of inappropriate care and support.

All accidents which occurred at the service were recorded and action taken to involve other health care agencies when required, for example, people attending the local accident and emergency department. The registered manager audited all the accidents and incidents which occurred at the service to establish any trends or patterns, or to identify if someone's needs were changing and they needed a review of their care. Accidents and incidents were also monitored centrally by the provider. They shared any findings with staff and these were discussed at staff meetings or sooner of needed. Referrals were made to specialist health care professionals, for example, the falls teams or the district nursing services.

We looked at the recruitment files of recently recruited staff. We saw these contained references, an application form which covered gaps in employment and experience, a record of the interview and a check with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These checks help employers make safer recruiting decisions and help to minimise the risk of unsuitable people from working with children and

vulnerable adults. The recruitment files also contained a job description and terms and conditions of employment.

The service was clean and well maintained and there were no malodours, staff had access to personal protective equipment such as gloves and aprons and we saw them using this appropriately.

Requires Improvement

Is the service effective?

Our findings

At the last inspection the provider was asked to take action with regard to the way the principles of the Mental Capacity Act 2005 (MCA) and the application of the Deprivation of Liberty Safeguards (DoLS) were adhered to. At this inspection we found this was still an area of concern and the requirement to improve this area of practise had not been met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that applications and authorisations had been granted for some of the people who used the service, however, we found some practises were undertaken by staff which had not been authorised under MCA process for example, the low level physical interventions used by the staff when supporting one people with personal care. To restrict people without following the principles of the MCA and the use of authorised DoLS means people are restricted or deprived of their liberty unlawfully.

This is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Need for Consent. You can see what action we have asked the provider to take at the end of this report.

People we spoke with were positive about the care and support they received. People who used the service told us they were happy with the food provided, comments included, "I like the food", "[I] can't speak for anyone else but I think it's lovely."

Visors told us, "My mum has very poor mobility and gets very aggressive, but they [the staff] are very good with her and very patient", "They seem to get the same staff to take care of mum and she recognises them." One visitor commented, "They [people who used the service] have a better social life than I do; they all seem to be happy." Visitors were positive regarding the food their relatives were provided with, one visitor told us, "The food here is marvellous you can fault it, there's plenty of choice." Another visitor told us they were satisfied with the level of support their relative received with regard to health care, "My mum can sometimes get skin tears when she gets aggressive and bangs herself on things, but they always phone me and let me know and if she needs the nurse to put a dressing on then they will get one and tell me."

The provider had systems in place to ensure staff received the training they needed to effectively meet the needs of the people who used the service. They monitored staff training and ensured this was updated when required. The provider had identified training which they considered mandatory for staff to complete. This

mandatory training included, fire training, safeguarding vulnerable adults from abuse, health and safety, moving and handling, first aid and dementia training. Staff also had the opportunity to undertake nationally recognised qualifications in care and to expand their knowledge and experience. Specialised training was also provided, this included, diabetes. Staff told us they found the training was adequate to allow them to meet people's needs, they said, "The training here is really good they [the provider] are always offering new courses" and "HICA [the provider] are really good at providing training, we get loads." All staff received regular supervision; this afforded them the time to discuss any work related issues. The staff received and annual appraisals where their training needs were discussed and any opportunities for further training explored. Newly recruited staff underwent a period of induction and this was based on good practise guidelines. Their competency was continually assessed and any areas which they were struggling with the provider ensured they got the support they needed to achieve this.

People who used the service were provided with a wholesome and balanced diet. The cook was knowledgeable about people's likes and dislikes; and an outside catering company provided a nutritionally balanced diet for older people. They understood the importance of providing a high calorie diet to those who had a poor appetite and provided fortified meals, drinks and snack for people to eat. We saw people's food preferences were recorded in their care plans along with their likes and dislikes. Food had been prepared to accommodate people's needs and pureed diets were provided where needed. People's food and fluid intake was recorded daily and they were weighed each week. If the staff identified any fluctuation in the person's weight they made referrals to the appropriate health care professionals for advice and assessments; they also made referrals if someone experienced other difficulties such as swallowing problems.

The food on the day of the inspection looked wholesome, nutritious and well presented. The majority of the people who used the service sat in the dining room to eat their meal and this was seen to be a social occasion with lots of chatting between themselves and the staff. More food was offered if people wanted it and some took up this offer. People were offered a cold drink with their meal and then a hot drink to follow. Staff discreetly assisted those people who needed help to eat their meal and various aids and adaptations were used to assist people to remain independent. However, on two of the bungalows the meal time experience for people who used the service was not relaxed and was chaotic, for example, staff did not ensure people ate their meals, staff took food away without asking if people had finished, people walked away from the table and were not brought back to finish their meals.
We recommend the provider undertakes an assessment of the meal times on each bungalow based on good practise guidelines around people living with dementia, to ensure these are a more pleasurable experience for people who use the service.

Staff monitored people's health and welfare and made referrals to health care professionals where appropriate. Care files showed staff made a daily record of people's wellbeing and what care had been provided. They also recorded when someone was not well and what action had been taken, for example, contacting their GP to request a visit. There was also evidence of people attending hospital appointments and the outcome of these.

The environment had been adapted to be dementia friendly; there were signs on all the bedroom doors with a picture of a bed, a photo, people's names and the number of the room. The bathrooms and toilets were well sign posted. There was a wedding room with photos of people's weddings and banners on the wall and a room with photos of tee shirts and posters of local football and rugby teams which were intended to stimulate conversations.

Requires Improvement

Is the service caring?

Our findings

During the inspection we were told by staff that a number of people were up when staff came on duty at 7am. Because of this following the initial two days of the inspection we carried out a further early morning visit to the service and found 10 people up in each bungalow at 6am. This equated to 30 people being up and dressed out of a total of 72. When we looked at people's care plans these did not specify whether this was the choice of the people who were up at 6am. We also saw during our observations of the lunchtime experience that one person was not supported in a dignified way and some people were subject to unlawful physical interventions. These practises do not uphold people's choice or maintain their dignity.

Despite the findings above when we spoke with people they were positive about the care and support they received.

When we spoke with the people who used the service they told us they found the staff kind and caring, comments included; "The staff here are lovely", "You couldn't wish for a better set of lasses they are angels" and "I get on fine with all of them we have a bit of laugh and joke, it makes the day go by."

Visitors we spoke with told us, "When my mum needs to be turned they [the staff] always knock on the door before they come in. They close the curtains and shut the door before they start to move her." Another visitor said, "I wait outside the room and I can hear them [the staff] talking to her and saying what they are going to do to make her comfortable." Another visitor said, "They [the staff] talk to her [visitor's relative] all the time." One visitor said "I had no hesitation to bring my mum in here and I would come in here myself if I could." Another said, "[The service has] a nice feeling" and went on to say "There is always someone buzzing about." however we did receive some negative comments from staff about staffing levels and people being up early which indicated some people were not treat with respect or their dignity upheld.

Staff seemed to have a good rapport with the people who used the service and there was a lot of laughter and good humoured banter around the service. Staff discreetly asked people if they needed any personal assistance. Staff understood the importance of respecting people's dignity and their right to privacy, they told us, "We get a lot of training about dignity and respect and how important this is so we try and make sure people are treated this way all the time."

Staff told us they understood the importance of maintaining and encouraging people to stay independent and maintain life skills, they told us, "Even if it just washing their [people who used the service] hands and face it's important to maintain those skills." Throughout the inspection we saw staff gently encouraging people to walk, eat and generally move around the building. They also discreetly undertook task with people describing what was happening and how they should assist the staff. Staff understood the importance of respecting people's cultural background or religious beliefs, they told us, "The residents chosen life style is nothing to do with us we are not here to judge but to support and help them."

People's care plans showed they or their representative had been involved with its formulation. People who used the service had signed to agree its contents and had attended reviews where their views had been

recorded. It was recorded in people's care plans if they could make decisions for themselves and if they couldn't who had been appointed to do this on their behalf.

The registered manager told us the service could access advocacy support if needed but none were currently being used. People were provided with information and explanations about the care and treatment they required in a way that met their individual needs. Information regarding Independent Mental Capacity Advocates as well as other advocacy services was displayed throughout the service. This helped to ensure people understood how they could access this support when required.

Staff understood the importance of keeping personal information confidential, they told us; "All information about the residents needs to be kept confidential, we have received training about this and the way information has to be stored." The provider had a policy about the use of mobile phones in the work place and staff conduct on social media.

From speaking with staff we could see that people were receiving care and support which reflected their diverse needs in respect of the nine protected characteristics of the Equality Act 2010 that applied to people living there which included age, disability, gender, marital status, race, religion and sexual orientation. This information was appropriately documented in people's care plans.

Requires Improvement

Is the service responsive?

Our findings

All the people who used the service had a plan of care; this had been formulated from the initial assessments undertaken by both the senior staff at the service and the placing authority. The assessment covered people's care and support needs in a range of daily tasks including mobility, medication, personal hygiene, eating and drinking, falls and memory. People and their relatives were involved in the assessment whenever possible which enabled them to provide feedback about their levels of independence and personal preferences.
The information gathered through the assessment process was used to develop care plans that included guidance to enable staff to meet people's needs. People's care plans contained information about their lives before they moved in to the service such as their family history, other important people in their lives, where they lived and grew up as well as any known hobbies or interests.
We found people's care plans did not always include information regarding their preferences. For example, the care plans of 30 people who were up and dressed at 6am did not state that this was their preference or choice.
The provider had failed to ensure people's care plans clearly reflect their needs and the way staff should support them. This is a breach of regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

People we spoke with were positive about the care and support they received, they told us they enjoyed the activities on offer at the service, comments included; "They [the staff] arrange lots of things for us to do", "We are always doing something, singing or dancing" and "I enjoy the things we do, we go out sometimes and visit other homes and see other people." People we spoke with told us they knew they could make a complaint and who this should be directed to, comments included; "I would tell the staff they sort it out for you" and "I would go straight to the boss."

Visitors told us they were happy with the level of stimulation their relatives received at the service, one visitor said, "Mum enjoys getting involved and doing the activities sometimes we [relatives] get involved as well, it's nice." Another told us "We have tea and coffee mornings." Visitors told us they knew they could make a complaint if they wished and knew the providers complaints process. One visitor said, "I have made a complaint in the past and this was dealt with professionally and thoroughly by the manager."

There was a number of activity co-ordinators employed at the service, both full and part time. They ensured there were plenty of activities on a daily basis for people to participate in. This ranged from tea dances, quizzes to sports days and 'Oomph' exercises. They were currently working with people to create a bowling green at the back of the service for people to use. The service had recently come first in a craft competition and had been awarded some tools and other craft making accessories for first prize.

The service produced a monthly newsletter which contained information about upcoming events; the recent edition reported on the service's open day which was celebrated with a tea dance. The newsletter also reported that 'Skype' (an internet based communication system) is to be introduced in the service to

help a number of people to keep in contact with relatives who lived abroad or too far away to visit. All activities were recorded on a daily basis to show the level of interest and participation, because any changes noted could potentially show changes in the person's needs. We heard staff talking and laughing with people around the building and these interactions were respectful and good humoured.

The provider had a complaints procedure which people could access if they felt they needed to make a complaint. This was displayed around the service and provided to people as part of the service user guide. The provider could supply the complaint procedure in other formats which were appropriate for people's needs, such as in another language or large print.

Inadequate

Is the service well-led?

Our findings

The provider had systems in place which were used to ensure the quality of the service was maintained; this included an early warning assessment which was used to pick up any issues quickly so these could be addressed. The provider also had external quality monitoring systems in place which looked at the performance of the service to establish if it was effectively meeting people's needs. However, despite these systems the provider had failed to identify the ongoing breach of Regulation 11 and the other issues identified by the inspection process. For example, people were still being restricted or deprived of their liberty unlawfully and the quality monitoring systems had not identified the ongoing breach. We found that a person was subject to low level physical interventions which had not been agreed or assessed as being in their best interest, people's needs were not met appropriately and their preferences were not always recorded.

The quality monitoring systems had identified the issues with the medicines but we found people had not always received their medicines as prescribed by their GP. Quality assurance systems had not been effective in identifying people's preferences for their care and support was not recorded in the care plans as required under Regulation 9. The provider had failed to have systems in place which ensured the service is safe, caring, responsive and well-led and provides people with safe and companionate care. This is a breach of regulation 17 Good Governance of the health and social care act 2008 (Regulated Activities) Regulations 2014. We are considering what further enforcement action we will be taking and will report on this at a later date.

Despite the findings above when we spoke with people they were positive about the care and support they received.

People who used the service told us they found the staff approachable, comments included; "The staff are good, I can talk to them if I want" and "I talk to the staff, they are good to us." None of the people we spoke with remembered attending any meetings but we did witness this during the inspection because there was a coffee morning and relatives had been invited to participate and give their views, along with the people who used the service.

Visitors we spoke with told us they had been asked for their views about the service and found the registered manager and other staff approachable. One visitor said, "We come to regular meeting and we discuss outings and how the home can be improved" and "I've come to all the meetings since [relatives name] has been in here, they do listen to what you have to say."

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They had sent the CQC notifications of any events which affected the well-being of people and the running of the service. This helps us so we can assess the ongoing management of the service.

The staff told us they found the registered manager approachable, they also found them supportive. One member of staff told us, "[Name of registered manager] is very supportive, I don't have a problem with her" another said "If I have any problems I can go to the manager she's okay." However, we did witness the registered manager speaking to some staff in a derogatory way when senior staff were assisting with the inspection of medicines systems at lunch time. We also found the registered manager was not fully engaged with the inspection process, this was especially noticeable during the out of hour's early morning visit where we had to actively seek them out to provide feedback. This was discussed with the senior manager for the organisation who stated this would be addressed.

Staff meetings had been held and we saw minute of these. The views of the people who used the service had been sought, as had other stakeholders who had an interest their care and welfare, for example, relatives and visiting health care professionals. These had been collated and a report published of the findings and any action to be taken to address shortfalls in the service identified by the respondents.

Staff understood they had a duty to report any problems to the senior staff on shift who would then inform the registered manager. They told us, "We have good lines of communication and I don't have problems speaking with senior staff" and "I report everything to the senior staff at the end of every shift and they pass it on to the next shift so we all know what's happening with the residents."

Maintenance certificates were up to date and all equipment used was serviced at the intervals recommended by the manufacturer. Fire drills and fire equipment test were carried regularly and a legionella test had been carried out.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's care plans clearly reflect their needs and the way staff should support them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's freedom was restricted unlawfully and without following the principles of the Mental Capacity Act (MCA) and without the use of authorised Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems in place which ensured the service was safe, caring, responsive and well-led and provided people with care which was safe and companionate