Abbeyfield Heswall Society Limited(The)

Heathermount Residential Home

Inspection report

Mount Avenue
Heswall
Wirral
Merseyside
CH60 4RH
Tel: 0151 342 1102
Website: www.abbeyfield.com

Date of inspection visit: 15 July 2015
Date of publication: 21/09/2015

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?	Good
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection carried out on 15 July 2015. Heathermount Residential Home provides privately funded personal care and accommodation for up to 17 older adults. Nursing care is not provided.

The home is a detached three storey house situated in Heswall, Wirral. The home is within walking distance of local shops and public transport. A small car park is available within the grounds. Accommodation consists of 17 single bedrooms with ensuite facilities. A passenger lift and stair lift enables access to all floors for people with mobility problems. Specialised bathing facilities are also available. On the ground floor, there is a communal open plan lounge/ dining room for people to use and a small garden for people to sit in and enjoy.

Summary of findings

During the inspection we spoke with six people who lived at the home, the registered manager, the home manager, two care staff and the cook. A home manager supervised the day to day running of the service and reported directly to the registered manager who managed the service.

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 our visit, a new home manager had recently commenced in post and was still in their probationary period of employment.

During our inspection we found breaches of Regulation 13 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People told us they felt safe at the home and they had no worries or concerns. Staff we spoke with were knowledgeable about types of abuse and what to do if they suspected abuse had occurred.

We found that a record has been made of incidents of a safeguarding nature but some lacked sufficient evidence that an appropriate investigation had been completed and preventative action taken. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some incidents had not been reported to either the Local Authority Safeguarding Team or to the Care Quality Commission. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.and indicated that some aspects of leadership at the service required improvement.

People who lived at the home said they were happy with their care and told us the staff looked after them well. Everyone held the staff in high regard and felt they had the skills and abilities to meet their needs. They told us they had good relations with the staff who supported them.

We saw that people who lived at the home were supported to maintain their independence and were able to choose how they lived their day to day lives. Activities were provided to occupy and interest people and interactions between people and staff were positive. The home had a warm, homely feel and the atmosphere was relaxed.

We observed that staff treated people kindly, with respect and supported them at their own pace. It was clear from our observations that staff knew people well and that people were comfortable and at ease with staff. Interactions between staff and people were warm, jovial and respectful.

People had access to sufficient quantities of nutritious food and drink and people said they were pleased with the choices and standard of the food on offer. We observed a medication round and saw medicines were administered safely but found the way in which medications from one medication cycle to the next were received and accounted for required some improvement.

Staff were recruited safely and there were sufficient staff on duty to meet people's health and welfare needs. Staff received the training they needed to do their jobs safely and appropriate managerial support to do their jobs effectively.

We reviewed three care records. Care plans and risk assessments provided staff with sufficient information on people's needs and risks and gave clear guidance to staff on how to meet them. Record showed people received prompt medical assistance in the event of ill health.

The majority of people who lived at the home had capacity to make their own decisions. We saw the beginnings of good practice in terms of obtaining people's consent in accordance with the Mental Capacity Act 2005. For example, the home had ensured people's level of capacity had been considered on admission to the home and regularly reviewed. It was evident in that the culture of the home was to support people with their consent and in accordance with their wishes. Further work was required however to make capacity assessments decision specific, where people were thought to lack capacity.

People were given information about the service and life at the home and regular resident meetings were held to keep people informed about issues associated with their

Summary of findings

care. People we spoke with and staff told us that the home was well led. We saw some evidence of this. For example, people were more than happy with their care, the home was clean and well maintained, staff were trained and knowledgeable about people's needs and a positive staff culture was evident throughout the home. Managerial improvements were required with regards to how the quality and safety of the service was assessed.

We found that there were a range of quality assurance systems in place, some of which were effective. Safeguarding audits, accident and incident analysis and medication audits required further improvement in order to be used to improve the quality of the service. At the end of our visit, we discussed the areas for improvement with the registered manager. We found that they were receptive and open to our feedback and demonstrated a positive attitude to resolving the issues.

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?

Requires improvement

The service was not always safe and required improvement.

People told us they felt safe and held the staff in high regard.

The provider had a safeguarding policy in place but where potential safeguarding incidents had occurred, there was limited evidence that appropriate safeguarding and reporting procedures were always followed.

People's individual risks in the planning and delivery of care were fully assessed. Appropriate risk management plans were in place and staff had simple but clear guidance on how to care for people safely.

Staff recruitment checks were undertaken and staffing levels were sufficient to meet the needs of people at the home

Medication was safely administered but there were some discrepancies in the way stock levels were accounted for.

Is the service effective?

Requires improvement

The service was generally effective but required improvement in one area relating to the mental capacity act.

People's mental capacity was assessed. Some good practice was evidenced in accordance with the Mental Capacity Act 2005 (MCA) but it required further development.

Staff received suitable training and supervision and had had their skills appraised. They said they felt supported by the management team.

People nutritional needs were met and people were given enough to eat and drink.

Is the service caring?

Good

The service was caring.

Everyone we spoke with spoke highly of the staff at the home and the care they received.

Staff were observed to be kind and respectful when people required support. People appeared relaxed and comfortable with staff.

People's independence was promoted and people chose how they lived their lives at the home.

Staff were familiar with people's needs and spoke warmly about the people they cared for.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People's needs were individually assessed and care planned. Care plans were easy to follow, person centred and regularly reviewed.

Records showed people had access to prompt medical assistance in the event of ill health.

A range of social activities were provided and the atmosphere at the home was social and interactive. This promoted people's well-being.

There was a complaints procedure in place displayed in communal areas. People and relatives we spoke with had no complaints.

Is the service well-led?

Requires improvement 

The service was not consistently well led and some aspects of management required improvement.

There were some good quality assurance systems in place to monitor the quality of the service but others were ineffective in identifying and managing potential risks.

Regular staff meetings took place and people's satisfaction with the service was sought through satisfaction questionnaires. People's feedback was positive.

We found that staff had a positive work ethic and staff morale was good. The culture of the home was open and transparent.

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

This inspection took place on the 15 July 2015. The first day of inspection was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspector and an Expert by Experience. An Expert by Experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with six people who lived at the home, the registered manager, the home manager and two care staff. We looked at a variety of records including three care records, three staff files, staff rotas, a range of policies and procedures, medication administration records and a range of audits.

We looked at the communal areas that people shared in the home and with their permission visited people's bedrooms. We observed staff practice throughout both of our visits.

Requires improvement

Is the service safe?

Our findings

We spoke with six people who lived at the home who told us that they felt safe living at the home. No-one we spoke with raised any concerns about the care they received and everyone we spoke with held staff in high regard. One person told us "Oh absolutely" when we asked if they felt safe, a second person told us "They're all good girls, can't complain. We're a happy family, you couldn't feel any safer put it like that" and another told us "Course I do (feel safe). I love it here".

The provider had a policy in place for identifying and reporting potential safeguarding incidents. We spoke with two care staff, both of whom demonstrated an understanding of types of abuse and the action to take in the event that any potential abuse was suspected.

We reviewed the provider's safeguarding records. We saw that although safeguarding incidents had been recorded, only some of the safeguarding records held sufficient evidence that an appropriate investigation had been undertaken by the home manager and some had not been appropriately reported to the Local Safeguarding Team or the Care Quality Commission. This meant there was little evidence that robust safeguarding procedures had been implemented to protect people from further potential risk. **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at the care plans belonging to three people who lived at the home. We saw that people's individual risks were assessed and considered in the delivery of care. For example, risks in relation to malnutrition, moving and handling, falls and the person's level of dependency were all assessed. . Where people occasionally displayed challenging behaviour, their risks had been considered and mitigated against with simple but personalised guidance for staff to follow. Personal emergency plans were also in place to advise staff how to safely evacuate people in the event of an emergency situation

We saw that the premises were well maintained and provided a clean and comfortable environment for people to live in. Annual health and safety checks were undertaken by the home manager to ensure that the premises remained safe and suitable for purpose. External contractors were employed to test and maintain the home's heating, electrical and gas systems, moving and handling equipment, fire alarm, bath hoists and the passenger lift. We saw that were repair issues were identified appropriate action had been taken. Environmental Health visited the home in February and gave the standard of food hygiene at the home a rating of five (very good).

The home had a warm, relaxed and homely feel to it, with an open plan lounge/ dining room that housed a small TV area surrounded by comfortable couches; a light and airy sitting room that looked out on the garden and a pleasant dining area in which people could enjoy their mealtimes.

The home had an infection control policy in place to minimise the spread of infection and we saw that the home manager regularly audited infection control standards. The last audit was undertaken in March 2015 and the home had achieved an overall score 96%. Where minor improvements had been noted, these had been actioned by the manager.

Accidents and incidents logs were completed for any accidents or incidents that occurred and a monthly audit of these was undertaken by the home manager to ensure appropriate action had been taken. We reviewed the accident and incident logs for April, May and June 2015 and saw appropriate medical assistance had been sought where this was needed.

We saw that people who were at a high risk of falls had fall detector wristbands in place to alert staff to potential accidents/incidents. The wristbands were linked to a pager system. Each staff member wore a pager that alerted them when a person had fallen. The wristband could also be pressed by the person to call staff for help in addition to the call bell system. One person told us that staff came straight away if they pressed the button on the wristband "You can't praise the girls enough. If you press the red button, they're straight here".

We looked at the personnel files of six staff. All files included evidence of a formal application process and checks in relation to criminal convictions and previous employment. This meant that the provider had ensured staff were safe and suitable to work with vulnerable people prior to employment. All staff files contained evidence that staff received a job related induction on appointment.

The majority of people we spoke with said there were enough staff on duty to meet their needs and that staff knew them well. They said a team of regular staff

Requires improvement

Is the service safe?

supported their needs. We saw from staff rotas that the home manager, a senior and two care staff were on duty each day. During the night, two care staff were on duty to ensure people's needs were met. We observed daytime staffing levels to be sufficient during our visit.

We looked at the arrangements for the safe keeping and safe administration of medicines at the home and found that some improvements in the storage and receipt of medication into the home were required.

We saw that medication was stored securely in a locked medication trolley stored in a locked medication room. There was also a locked medication fridge for medications that required refrigeration. Daily temperatures checks of the room in which the medication was stored, and the fridge, were undertaken to ensure medicines were stored at a safe temperature. We reviewed a sample of the daily temperature checks undertaken in July 2015 and found that on more than one occasion, room and fridge temperatures had exceeded safe temperature levels. We asked the home manager about this who was unable to say what action had been taken.

Medication was dispensed in monitored dosage blister packs. We checked a sample of two people's medication administration records (MARs) and found that both medication records matched what medicines had been administered.

We checked a sample of people's boxed medications to ensure that the amount of medication left in the person's medication box matched what had been administered. We found that for some medicines it was not always possible to tell how much medication should have been left in the box as the receipt of medicines into the home and records of medicines brought forward from previous medication cycles were incomplete. This meant we could not tell whether the medicine had been administered appropriately. The home manager told us the medicines in question had only been received by the home on the day of our visit. For those medications where stock levels had been carried forward correctly, the balance of medication matched what had been given. This provided some assurances that boxed medication had been given correctly.

One person's medication instructions had been manually changed on the person's MAR. There was no reason for the change documented on the person's MAR and no signature to indicate who had made the change and when. This meant there was no evidence that the change on the person's MAR had been authorised. We spoke to the home manager about this who said they would look into it without delay.

The home manager told us all staff administering medication had been appropriately trained in the safe administration of medication. This was confirmed by two other staff members. We observed a staff member undertake a medication round during our visit. We saw that the way in which they administered medication to people who lived at the home was safe.

Requires improvement

Is the service effective?

Our findings

All of the people we spoke with told us that staff had the skills to meet their needs. Everyone spoke highly of the staff in terms of both their competency and attitude in the delivery of care. They felt that staff knew them well and understood their needs. One person said they were cared for "Very, very well indeed, I can't praise them enough". Other people's comments included "The staff are excellent"; "They've certainly been well trained" and "They know what to do, that's how I'd put it"".

The registered manager told us the provider operated an annual mandatory training programme. Staff we spoke with told us they had been trained to do their jobs. Staff training records confirmed this. One staff member told us that a full programme of training was offered twice a year.

Staff were offered training in a wide range of health and social care topics such as the National Vocational Qualifications (NVQ) Level 2 and 3 qualifications; the safe administration of medications, moving and handling, safeguarding, dementia awareness, pressure ulcer care, first aid, mental capacity/deprivation of liberty safeguards. This demonstrated that suitable training was provided to staff to ensure they were able to meet the specific needs of the people they were cared for.

The two care staff we spoke with told us that they received regular supervision in their job role and that they skills and abilities were appraised to ensure they were competent. Records confirmed this. This showed that staff received adequate managerial support to enable them to carry out their responsibilities effectively.

We observed the staff team supporting people throughout the day and from our observations it was clear staff knew people well and had the skills/knowledge to care for them.

The registered manager told us the majority of people who lived at the home had the capacity to make their own care and lifestyle decisions. We saw staff throughout the day checking people consented to the support they were being given.

We looked at the care plans of three people who lived at the home and saw the beginnings of good practice in relation to people's mental capacity or short term memory loss. We saw that in all three files a general assessment of the person's mental capacity was undertaken on admission to the home. People's level of capacity had been regularly reviewed and care plans provide simple guidance on people's wishes in relation to their care.

Of three care plans reviewed one person's care plan indicated they lacked the capacity to make certain decisions. We saw that although this person's capacity had been reviewed, this person's mental capacity assessment was generic and did not specifically relate to the types of decisions the person could make. We spoke to the registered manager about this as there was a risk that staff may presume the person had no capacity to make any decisions at all. The manager agreed this was an area for improvement.

Where people had communication difficulties, simple guidance was provided to staff on how to communicate with the person prior to and during the delivery of care. This included the use of non- verbal communication. The use of non-verbal communication could have been further improved by the use of pictorial aids and we spoke to the manager about this. Pictorial aids are a set of pictures that are designed to convey a certain meaning or feeling for example, "I am hungry" or "I am sad". They enable people with verbal communication difficulties to communicate their needs, wishes or feelings to staff. It was evident however within people's care plans that communicating with and respecting the people in order to seek their consent was important in the delivery of care.

Consent forms were in place in all three care files we looked at. For example, consent forms were in place for the taking and use of photographs and the administration of medication by staff. For the person who lacked capacity, these consent forms had been signed by the person's relative. The Mental Capacity Act 2005 (MCA) states relatives cannot be asked to sign consent forms when a person lacks capacity unless they have authority to make health and welfare decisions for the person under a Lasting Power of Attorney or a Court Appointed Deputy. Neither of these provisions were in place. We discussed this with the registered manager.

We saw that the provider offered training in mental capacity, the deprivation of liberty safeguards (DoLS) and dementia awareness to all staff members. The manager and staff we spoke with had a good basic understanding of

Requires improvement

Is the service effective?

the Mental Capacity Act 2005 and DoLS. The registered manager acknowledged however that some improvements were needed with regards to its implementation in practice.

People spoke highly of the food on offer at the home and told us they received plenty to eat and drink. Their comments included; “Oh its very adequate, nice, good really; “Very good, very good indeed”; “The meals I’ve had so far are absolutely delicious” and “It’s is very good. You can pretty much have what you want really”.

People told us they were given the menu options each day verbally by a member of staff who came around with the menu information. We spoke with the cook on duty who told us that food was “home cooked” and “a mixture of fresh and frozen food”. A four week rolling menu was on offer and the cook told us that they “Always get other things in for people who don’t want what’s on the menu”. We checked the home’s food stores and saw that they were well stocked and organised.

We observed the serving of the lunchtime meal. We saw that the dining room table was nicely decorated with tablecloths, napkins and china dinnerware with a good range of condiments available. The dining room was light, airy and the lunchtime meal was served in a pleasant, social atmosphere.

People’s meals were served promptly and pleasantly by staff. There were two choices on offer on the day of our visit either roast chicken or lamb dinner. We saw that portion sizes were satisfactory. A selection of vegetables was placed in the middle of the table so that people were able to help themselves to more if they wanted. We heard staff offer people additional portions and alternatives if they did not like what was on offer. The mealtime was unrushed and people were able to take their time to socialise and relax after their meal.

We saw that people’s nutritional needs were assessed and their likes and dislikes with regards to food and drink noted in the planning and delivery of care. People were weighed and their nutritional risk reviewed monthly. Information was displayed in the kitchen which identified which people had food allergies or special dietary requirements and catering staff knew what these were.

Records showed that people had prompt access to medical and specialist support services as and when required. People we spoke with confirmed this. Where people were involved with health care professionals, the advice given was documented in care files for staff to follow. People’s daily notes showed that staff were monitoring people’s health and wellbeing on a daily basis and responding appropriately to signs of ill health.

Good

Is the service caring?

Our findings

People we spoke with said they were well looked after. When asked how staff treated them, their comments included “Do anything for you the girls. Marvellous, marvellous, perfect as practically possible”; “Excellently, they’re police, they’re kind and they’re attentive, yes can’t ask for more than that” and “Too well, I feel I am undeserving of this, they have the best intentions. They treat you well”.

We asked two staff about the care they provided and the people they cared for. We asked them how they protected people’s right to privacy and dignity and promoted people’s independence in the delivery of personal care. Both staff members gave clear examples of how they did this on a daily basis and had a good understanding of people’s needs.

During our visit, we saw that staff interacted with people in a warm, kindly manner. They maintained people’s dignity at all times and people looked well dressed and well cared for. Staff were respectful of people’s needs and wishes at all times and supported them at their own pace. From our observations it was clear that staff genuinely cared for the people they looked after and it was obvious that people felt comfortable in the company of staff.

We saw that care plans outlined the tasks people could do independently and what people required help with. We saw people were able to have a key to their room if they wished and were able to self- administer their medication if they preferred. This promoted people’s independence. When asked, people we spoke with said that staff supported them to be as independent as possible in tasks of daily living.

We saw evidence that end of life discussions had taken place with people and their relatives with people’s preferences and wishes recorded. This showed us that the home understood and respected the advance decisions made by people in respect of their end of life care.

The home had a service user guide for people to refer to. We looked at the information provided and saw that it was an easy to read guide to the home, its staff and the services/facilities provided. A resident newsletter was also produced, updating people on any news and forthcoming events. This showed that people were given appropriate information in relation to their care and the place that they lived.

Regular residents’ meetings were undertaken where people were able to express their views about the care at the home and suggest improvements. For example, the last resident meeting took place in July 2015 and people at the home were able to express their views with regards to menu planning, the home’s activities and the potential purchase of mini- van.

Good

Is the service responsive?

Our findings

Everyone we spoke with was happy with the care they received. Comments included “Treated very, very well indeed. I can’t praise them (the staff) enough”; “Oh very well, yes they’re a hard working band” ; “Oh yes, I don’t see they could do much more for us really” and “Absolutely, marks 150!”

When asked if they felt staff knew them well and understood their needs, one person told us “Oh absolutely, in fact they have been marvellous” and another said “Yes, the staff are excellent”.

We saw that each person’s care file contained a person centred assessment and care plan. Assessment and care planning information identified people’s needs and preferences in the delivery of care. Preferences in food and drink, activities and religious needs were also documented.

People’s care files contained information about the person’s life history for example, education, employment and family life. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia.

Care plans and risk assessments were reviewed monthly and were clear and easy to follow.

People’s care plans included details of their social interests and the activities they enjoyed. People confirmed that there were activities of offer and said they were free to come and go at the home as they pleased. The home did not employ an activities co-ordinator but activities were provided each day by the care staff.

On the morning of our visit, a pampering session took place in the lounge with two people receiving facials. The session was done in a dignified way and staff sat and socially chatted to people whilst the session took place.

We saw that the residents’ noticeboard promoted forthcoming events such as a summer open day with barbecue and a music workshop in July 2015. A daily record of the activities undertaken at the home was kept which indicated a range of activities were offered such as films, quizzes, poetry, exercises and a pub event. The daily activities log only recorded activities up to the end of May 2015.

People’s care plans showed that they were given a choice about how they wished to be cared for and what they liked and disliked in the delivery of care. People we spoke with confirmed this and said they could choose how they lived their day to day life.

We saw that the complaints procedure was displayed in the entrance area of the home. The complaints procedure gave a clear timescale for responding to people’s complaints or concerns and the contact details for who people should contact within the organisation. Contact details for the Care Quality Commission and the Local Government Ombudsman were also provided.

We asked the registered manager if any complaints had been received since our last visit. They told us none had been received. No-one we spoke with had no concerns or complaints about the care they received.

Requires improvement

Is the service well-led?

Our findings

All of the people who lived at the home and their relatives told us they knew the registered manager and the staff team well.

The registered manager at the home was also the registered manager for the provider's two other care homes in Heswall. Each of the provider's three homes had a home manager involved in the day to day running of the service. Home managers reported directly to the registered manager. The registered manager told us that they tried to visit each service at least one day a week. A new home manager had recently been appointed and was still in their probationary period of employment.

We saw that the registered manager and the previous home manager had undertaken a range of monthly audits to monitor the quality and safety of the service provided at the home. This included a monthly audit of care planning; medication audits, accident and incident audits, six monthly infection control audits and an annual health and safety audit. During our visit we found that some improvements in the way the service was managed and monitored were needed.

Improvements were needed in how the service fulfilled its legal responsibilities to report notifiable incidents to the Local Safeguarding Authority and the Care Quality Commission (CQC) where required. Notifiable incidents are certain things that registered services need to notify the Local Safeguarding Authority about under Local Authority guidelines and CQC under the Care Quality Commission (Registration) Regulations 2009.

Safeguarding audits which were undertaken every six months, were not frequent enough to identify that some of the recorded incidents in the last six months, lacked evidence that an appropriate safeguarding investigation had been undertaken. They also failed to identify that some incidents had not been appropriately reported to the local authority or the CQC. The provider's own policy acknowledged that "The manager should notify the CQC of the incident in accordance with registration requirements".

For example, we looked at a sample of safeguarding and other untoward incidents records at the home in February, March and June 2015. We found that five incidents of a safeguarding nature had not been appropriately reported. We spoke to the registered manager who acknowledged that these incidents had not been reported.

Monthly accidents and incident audits were completed but were too brief to enable the analysis of trends for example, location and time of accident/incidents, type of accident/ incident and staff on duty. This meant that there were no effective learning systems in place to identify, assess and manage the risks posed to people using the service from similar incidents occurring.

Monthly medication audits were undertaken monthly but were too limited. We reviewed the audits completed January, February and July 2015 and saw that only one person's medication administration records and supplies were audited each month. This meant there was a risk the audit did not give a full picture of the standard of medication practice at the home.

These incidences were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured effective systems were in place to assess and monitor the quality and safety of the service. They had also failed to appropriately share relevant information relating to notifiable incidents to The Commission.

During our visit we found the culture of the home to be positive and inclusive and we saw some evidence of good leadership. For example, staff were friendly, welcoming and hospitable to visitors. They were observed to have good relations with each other and were caring and warm in all their interactions with people at the home.

The home itself was well maintained, free from hazards with good infection control standards. Everyone we spoke with was positive about the care they received and said they were happy living at the home. Staff we spoke with said both the registered manager and the new home manager were approachable and supportive. One staff member told us that the home was well managed, organised and the staff team knew their routines.

We saw that regular staff and management meetings took place and staff told us they felt able to express their views. We reviewed the minutes of the staff meeting held in July and April 2015 and the minutes of the management

Requires improvement

Is the service well-led?

minutes held in April 2015. We saw that issues associated with the running of the home, staffing issues and resident care were discussed. Where actions had been identified these had been acted upon. From the minutes it was clear that the provider and the management team were committed to continuous improvement.

The manager told us a satisfaction questionnaire was sent out to people and/or their relatives on an annual basis and that the results were analysed. They showed us the results of the last survey undertaken on the computer screen and we saw that the home had achieved 91% satisfaction levels.

At the end of visit, we discussed the areas for improvement identified during our inspection with the registered manager. We found the registered manager to be open and receptive to our feedback. They had already identified that some improvements in the management of the home were required and had made some changes. They took on board that some improvements were still required and displayed a positive attitude to making these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems in place to investigate and protect people from abuse and improper treatment were not operated effectively. Regulation 13(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to have effective systems in place to identify and assess the risks to people's health, safety and welfare and failed to appropriately share information relating to notifiable incidents with The Commission. Regulation 17(2)(a) and (b).