Roseberry Care Centres GB Limited

Hylton View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 26 January 2018. The first day of inspection was unannounced and the second day announced. When we last inspected the home we found the provider had breached the regulations relating to assessing safe care and treatment because people were left unsupervised in communal lounges for long periods and medicines were not managed safely. We also rated the home as Requires Improvement. Following this inspection we have again rated the home as Requires Improvement. This is the third consecutive time the home has received this rating.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions is the service safe, caring and well-led to at least good. We requested the provider supply the Commission with regular updates to enable close monitoring of progress. We found progress had been made and the provider was now meeting the regulation. We noted that throughout our inspection staff supervised communal lounges at all times to help keep people safe. People told us staff responded to their requests for assistance quickly. Improvements had been made so that medicines were manged appropriately. Records and our own observations confirmed people received their medicines safely.

Hylton View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hylton View accommodates up to 40 people across two separate units, each of which have separate adapted facilities. At the time of our inspection there were 35 people using the service, some of whom were living with dementia.

Since our last inspection the home had employed a new registered manager. 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. People, relatives and staff described the registered manager as approachable and supportive.

During this inspection we found the provider had breached the regulation relating to good governance. Quality assurance audits had not always been effective in identifying concerns, such as the lack of an in-depth falls analysis and inaccurate information in falls care plans and risk assessments.

You can see what action we told the provider to take at the back of the full version of the report.

Although we found improvements were required to the oversight of falls management in the home, the provider had ensured the relevant practical steps were in place to minimise the risk of individual people from falling. For example, increasing observations, providing specialist equipment and referring people to the falls team.

People, relatives and care workers told us the home was a safe place to live. People also described their care as good and said staff were kind and considerate.

Staff were knowledgeable about safeguarding and were aware of the provider's whistle blowing procedure. Staff knew how to report concerns and confirmed they would have no hesitation in doing so if required. Previous safeguarding and whistle blowing concerns had been dealt with appropriately.

The provider completed various pre-employment checks to help ensure new care workers were suitable to care for people living in the home.

Regular health and safety checks were carried out to help keep the premises and specialist equipment safe to use. For example, checks of fire, gas and electrical safety. The provider also had policies and procedures to deal with emergency situations.

Staff told us they were well supported and received the training they needed. Supervisions, appraisals and training were up to date.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff supported people with maintaining their nutritional requirements in line with their individual needs. Where prompts or assistance were needed this was provided in a timely way.

People had input from external health professionals depending upon their individual circumstances. For example, GPs, community nurses and speech and language therapists.

People's needs had been assessed both before and on admission to the home to identify their individual care needs. Although falls care plans were not accurate, the other care plans we viewed reflected people's needs and were up to date.

There were daily opportunities for people to participate in activities. These included trips out, memory quizzes, cinema nights, keep fit, singers, board games, cards and dominoes.

People gave us positive feedback about the care they received. Previous complaints had been investigated and resolved in line with the provider's complaints procedure.

The registered manager held daily meetings with key staff to share important information about people using the service.

People and staff had regular opportunities to share their views about the care provided at the home through attending meetings.

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.

The systems for monitoring and analysing incidents and accidents were not effective.

Staff knew how to report concerns using the safeguarding and whistle blowing procedures.

Improvements had been made so that medicines were now managed safely.

People confirmed there were sufficient staff to respond to their requests for assistance.

The provider followed an effective recruitment process when employing new staff.

The provider had a system of regular health and safety checks in place.

Is the service effective?

Good

The service was effective.

People's needs had been assessed.

Staff confirmed they received good support. Records confirmed supervisions, appraisals and essential training were up to date.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS).

People received the support they needed to meet their nutritional and health care needs.

Is the service caring?

Good

The service was caring.

People and relatives gave us positive feedback about the care

provided at the home.

People were treated with dignity and respect.
Staff aimed to promote people's independence as much as possible.

Is the service responsive?

Good

The service was responsive.

Most care plans were personalised and had been updated to reflect people's current needs. .

People had the opportunity to participate in a range of activities.

People have us positive feedback. Previous complaints had been investigated and resolved in line with the provider's complaint procedure.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems had not identified shortfalls in the monitoring of incidents and accidents or inaccurate information in falls care plans and risk assessments.

The home had a registered manager who people and staff described as approachable and supportive.

Regular meetings took place involving people and staff.

The provider had an improvement plan for the home and was making progress.

Hylton View

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 was prompted in part by a notification of an incident in which a person using the service sustained a serious injury and died. We have completed an initial review of this incident and at this stage have closed our enquiries with no further action taken. However, the information shared with CQC about the incident indicated potential wider concerns about the management of the risk of falls in the home. During this inspection we examined those risks.

This inspection took place on 9 and 26 January 2018. The first day of the inspection was unannounced and the second day was announced. One inspector, a specialist advisor who was a qualified nurse and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider 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. Before the inspection we reviewed the information in the PIR as well as all the information we held about the service, this included notifications of significant changes or events.

Prior to the inspection we contacted external commissioners of the service from the local authority and the Clinical Commissioning Group (CCG), as well as the local authority safeguarding team and the local Healthwatch. We used their feedback during the planning of this inspection.

During our inspection we spoke with nine people and five relatives. We also spoke with a range of staff including the regional manager, registered manager, one nurse, two senior care workers and two care workers. We reviewed a range of records including five people's care records, medicine records, five staff files, training records and other records relating to the quality and safety of the home.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection we received information which suggested people at risk of falling might not receive the support they needed to keep them safe. However, when we inspected we found the provider had taken action to implement various strategies depending on people's needs. This included increased monitoring, referrals to a specialist falls team and specialist equipment, such as sensor mats to alert staff to people's movements.

Although practical steps had been taken to keep people safe, records we viewed relating to the risk of falling were not accurate. We found these inaccuracies had not been identified and rectified through the provider's internal governance arrangements. On admission to the home the provider completed a range of assessments to help protect people from a range of potential risks, including the risk of falling. However, we found falls assessments were not always completed accurately and in some cases underestimated the risk to people using the service. For example, the assessment used prompted staff to provide a score based on the person's falls history. For one person, staff had scored this as '2' which was the score relevant to when a person had fallen '1 or 2 times before, but not in the last 48 hours'. However, the person had experienced more than two falls which meant their score should have been '4'. This meant they had been scored as a 'low risk' rather than a 'medium risk'. Although the risk assessment for this person was inaccurate a falls sensor was still in place.

Care plans did not accurately account for the support people received in relation to reducing the risk of falls. For example, one person's 'falls care plan' stated they had bedrails in place. However, the registered manager confirmed this was no longer the case. Other care plans we viewed did not include the fact that people had equipment in place such as sensor mats.

We also found staff did not follow people's care plans which stated falls risk assessments should be reviewed following each fall. Although we noted falls risk assessments had been reviewed each month this was not prompted by a fall and made no reference to the falls the person had experienced in the preceding month. This meant it was not possible to be certain the falls risk assessment was still relevant to the person's current needs.

The provider had a regular system in place to monitor and analyse incidents and accidents including falls in the home. However, we found this was not done effectively and lacked an in-depth analysis meaning some trends and patterns were not explored sufficiently. The tool used to record the analysis included a series of prompts to ensure relevant information was considered during the assessment. This included questions such as: 'When is the time when the highest number of falls occurs'; and 'Can a theme be identified?' We found these questions were not always answered accurately and in enough detail. For instance, we viewed the analysis carried out between November and December 2017. The analysis identified when the highest number of falls took place and in which area of the home. In this case over the lunchtime period in communal lounges. We found there was no reference to this in the analysis and no consideration given as to whether this was linked to the deployment of staff over specific times of the day, for example lunchtime. The analysis went onto identify the highest number of falls occurred from lunchtime and through the night in

people's bedrooms. The action recorded to address this was 'to discuss with the RGN and alert staff to be in lounge area observing.' However, this did not appear an appropriate response as the falls occurred during the night and in people's own rooms rather than communal lounges.

On those occasions where trends had been identified such as infections and falls in bedrooms it was unclear from the analysis what action had been taken to address these issues.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection we observed communal lounges were left unsupervised for long periods of time. We checked the communal lounges at various times throughout this inspection and found staff members were present at all times to help keep people safe. One new member of staff commented, "The lounge is always supervised for falls risks. It has been the whole week I have been here."

Improvements had been made since our last inspection so that medicines were usually managed safely. We observed nursing staff followed the provider's medicines policy and adhered to good practice. Staff, with responsibility for administering medicines, were knowledgeable about the medicines given to people. We noted they waited with people to ensure they took their medicines safely before moving to the next person. People's medicines administration records (MARs) were completed correctly which meant there was an accurate record of the medicines people had received. We noted some records relating to stock balances were not always accurate. For example, for four people we saw records showed no medicines had been received into the home from the previous four weekly cycle and no medicines carried forward, however medicines were still being administered.

Medicines were stored safely and securely. Treatment rooms were very spacious, clean and tidy. Checks were made of the treatment rooms and medicine fridges to ensure medicines were stored at the correct temperature. Drugs liable to misuse, also known as controlled drugs, were handled appropriately. We asked people if they received their medicines when they were due and they confirmed they did. One person said, "I always get my tablets on time."

People told us they felt safe living at Hylton View. One person said, "Yes, we can lock the doors but we would be safe even if we left them open." Another person told us, "I lock my door as it gives me greater security and peace of mind, nobody wanders in here. There is no bullying or harassment, if there was they would get more than they bargained for." A third person commented, "I moved here to feel safe as I wasn't safe in my own home. I feel safe here … we all feel safe here." One relative said " Oh [family member] is very safe in every way, it's clean, tidy. [Family member] is well fed, her health is looked after."

Staff also told us they felt the home was safe. One staff member commented, "I have no concerns. We chat with people, we sit and talk to them. We tell them if they have problems to let us know." Another staff member said, "Safe, yes we have codes on the doors. We are on the ball."

Staff knew about the provider's whistle blowing procedure and had a good understanding of safeguarding. One staff member told us they had previously used the whistle blowing procedure. They told us concerns had been taken seriously and dealt with. Other staff said they would have no hesitation using the procedure if needed. One staff member commented, "I would go to the manager. If they didn't do anything I would go further afield." Another staff member said, "I would use it [whistle blowing procedure]. I would report concerns to the senior, manager or home manager." We viewed the safeguarding log and associated records which confirmed safeguarding concerns had been dealt with appropriately. This included making a referral

to the local authority safeguarding team and fully investigating each incident. Where required action had been taken to help prevent the situation from happening again. Actions included supervision sessions with individual staff members, contact with health professionals, involving relatives and reviewing care plans.

We received mixed feedback from people and relatives about staffing levels in the home. Some people felt there should be more staff around. However, all people we spoke with confirmed staff responded to their calls for assistance without delay. One person said, "They are very, very good indeed and they come as fast as they can. I pressed my buzzer during the middle of the night thinking it was morning last night and they came straight away." Another person told us. "I can't fault any of them. If I want anyone I just raise my voice and someone comes like a shot."

Staff said staffing levels were sufficient to meet people's needs in a timely manner. One staff member said, "We always have five upstairs. There is always plenty of staff. We can supervise people with that number." Another staff member commented, "They [staffing levels] can be fine. There are enough to meet people's needs, we can respond to needs quickly."

The provider used a staffing dependency tool to help monitor the appropriate staffing levels for the home. This had recently been implemented from the beginning of January 2018. The analysis showed the actual staff deployed at the home was in excess of the number recommended by the dependency tool.

People who displayed behaviours that challenge received appropriate support from staff. Staff showed a good understanding of how to support people in these situations. They had also made referrals to community professionals for advice and guidance. This included community psychiatric nurses (CPN), social workers and the challenging behaviour team. Care plans described the strategies required to keep people and staff safe such as frequent observations, sensor alarms and de-escalation strategies. One relative described how staff were able to prompt and encourage their relative in a way they couldn't. They commented, "They have what it takes to persuade [family member]. I think [family member] is well looked after."

Health and safety checks were completed regularly to help keep the premises and equipment safe for people. For instance, checks were in place relating to fire, gas and electrical safety. Up to date risk assessments were available covering areas such as Legionella, fire safety and the use of specialist equipment used to help people with mobilising. During our visits to the home we observed the maintenance person checking equipment to ensure they were in good working order. The provider had procedures in place to deal with unforeseen emergency situations.

We found the home was mostly clean, fresh and well decorated. Throughout our visits to the home we observed domestic staff carrying out cleaning duties. People's rooms we visited were very clean, well arranged and personalised to people's individual preferences. However, we did note that on the first day of our inspection the upstairs dining room had not been cleaned after breakfast. This meant when people arrived for lunch there were crumbs on the floor and dirty crockery, cutlery, serviettes and dignity aprons on some of the tables. We brought this to the attention of the registered manager and regional manager. They told us this was not usual and would investigate the matter. On our second day we checked this dining room again and found the issue had been resolved. We saw the dining room was clean and tables had been set with fresh flower arrangements.

Good

Is the service effective?

Our findings

We observed over the lunchtime to help us understand people's meal time experience. We noted people had a pleasant experience in the downstairs dining room. Ten people were present with four staff available to provide support. Four people preferred to eat in their own rooms and this was respected. Music played in the background to provide a relaxing atmosphere. People were offered a choice of hot and cold drinks. People were offered a dignity apron to protect their clothes. People were offered a choice of meal with some making specific requests. These were provided without a problem. We noted staff chatted to everyone and coaxed and encouraged people where required. People were not hurried and able to eat at their own pace.

People in the first floor dining room did not always have a pleasant experience. We initially found the dining room was not clean and there was a lack of organisation. For example, tables hadn't been set prior to people entering the dining room, staff were unable to locate the 'choices sheet' which indicated what meal people had chosen and the meals trolley was taken away before people finished their meal. We observed a team leader was present in the room who effectively took control of the situation. They were proactive and directed staff calmly throughout the lunchtime so that issues were quickly addressed. For instance, they prompted staff to serve people's meals together so that everyone sat at a table had something to eat. They encouraged staff to sit with people to offer support and stimulate conversation.

We discussed the lunchtime experience with the registered manager and regional manager. They told us they regularly checked the dining experience and had not observed this before. They said they felt staff might have been affected as they were aware they were being observed.

Each person had a 'diet notification form' which provided information for kitchen staff about their dietary needs. For example, details of allergies and any special dietary requirements people had such as altered textures and thickened fluids. The form also highlighted people's food and drink likes and dislikes. Where people had been assessed as at risk of poor nutrition, appropriate action had been taken to help keep them safe. This included referring people to external health professionals for specialist advice and guidance. For example, a Speech and Language Therapist (SALT) had assessed and reviewed one person. Their advice had been incorporated into the person's care plans for staff to follow. Other records showed the person had been closely monitored including assessing their nutritional needs, checking their food and fluid intake and monitoring their weight.

Other records showed people had been referred to various health professionals for additional advice and guidance or when they were unwell. This included GPs, community nurses and specialist nurses.

People and relatives told us they thought staff had the correct skills to be able to meet the needs of people living at the home. One person said, "Yes, they do everything very well. They are very good with the hoist, they are excellent with it. As I can't really do anything for myself … nothing is too much trouble for them." Another person said, "Of course they are well trained. If they weren't I wouldn't be here would I." One relative commented, "I've never had any reason to question the staff training."

Staff were well supported and received the training they required. One staff member said, "I can go straight to the manager or nurse on duty. They always ask if we want any training. If you have a problem, just go to [registered manager] and she will help you out." Another staff member commented. "I am very well supported, [registered manager] is very approachable. I wouldn't have any problem going to her about anything. Every so often we have supervision. The staff support each other as well." Essential training for staff included moving and handling, nutrition, infection control and equality and diversity. The provider's expectation was for staff to have a minimum of four supervisions and an annual appraisal. Records showed training, supervision and appraisals were up to date when we inspected.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. The provider maintained a DoLS application and tracking log. This provided details of people requiring a DoLS authorisation, the date it was authorised and when they were due for renewal. The log showed all DoLS authorisations had been granted and were in date.

We found examples of MCA and best interest decisions within people's care records such as for the covert administration of medicines. Care plans describing when and how these medicines should be given were also in place to guide staff appropriately. Staff described the various strategies they used when supporting people with making decisions and choices. This included using recognised gestures, key words, showing people items of clothing to choose from and using pictures for meal choices.

Good

Is the service caring?

Our findings

People told us they received good care at the home. One person told us, "Yes, I'm well cared for. When I came in here I couldn't walk and now I can. I can't thank them enough." Another person commented, "I wouldn't like to be anywhere else. I'm happy here, this is my home." One relative said, "It's exceptional care and no one will have any problems." Another relative told us, "It's brilliant, they explain everything … I can't fault anything at the minute. We are impressed with the way they have cared for [family member]. I think he is well cared for."

People said care staff were kind, caring and considerate. One person commented, "Yes, they (care staff) are good … they are very understanding." Another person said, "The carers can't be faulted." I can have a laugh with them." One relative told us, "[Family member] is very nervous but the carers pop in all the time to cuddle her or hold her hand so that she gets assurance. I can go home with a weight off my mind knowing she is okay. My sister looks after her care plan but we can look at it anytime we want."

People were treated with dignity and respect. They were also supported to be as independent as possible. One person said, "They (care staff) help to keep my dignity and independence as I do as much as I'm able and they do their job really well." Another person told us, "If they can help they will help but always trying to keep you mobile and independent." A third person said, "If I want to go out my daughter takes me in my wheelchair. We can just come and go when I please. It's not a prison, it's our home and we treat it like it." A third person commented, "I try to shower myself." One relative said, "[Family member] is 87 and they try to keep her independent. The best thing that ever happened was when she came in."

Staff showed a good understanding of the importance of promoting independence, dignity and respect. One staff member said "We talk to people all the time. We let them do things for themselves. We wouldn't take away their independence. If they can't manage we would help them." They gave us examples of practical things they did when supporting people to promote privacy and dignity. For example, closing curtains, closing doors and keeping people covered up as much as possible.

People told us staff supported their choices and preferences. One person commented, "I can't move out of this chair so the carer's do me [support with a shower] every two days but that is my choice." Another person said, "I could have a shower every hour if I wanted one." It was apparent from our discussions with staff that they knew people well and were aware of their individual preferences.

People told us staff did their best to find one to one time to sit and chat with them. One person said, "They come in numerous times a day and try to chat to everyone, I can't fault them." Another person told us, "They chat away and listen, but we could do with more staff so we could chat more."

Good

Is the service responsive?

Our findings

Most people we spoke with were happy staff knew about their individual needs and the care they needed. They also confirmed they did not feel they needed to be involved in their care planning or reviews.

Care plans, apart from those we viewed for people at risk of falling, were detailed, personalised and up to date. They described the support each person needed including details of any preferences they had. Care plans incorporated the views of professionals involved in people's care. Where risks had been identified, a risk assessment had been completed. Where people had specific health or other needs, care plans had been written to meet those needs. For example, where people had diabetes or specific needs relating to communication.

Activity records were kept for each individual. This gave details of their preferred activities and of any activities they had taken part in. There were a range of activities for people to participate in. This included weekly trips out, memory quizzes, cinema nights, keep fit, singers, board games, cards and dominoes. One person said, "I like bingo which is on twice a week. It should be more and I like to go out." One relative commented, "They have a mini bus so more people can go out as soon as the weather improves." Another relative told us, "I'd make no changes other than there should be more theatre trips and to organise more mini bus trips."

We observed a 'musical memories' activity which as taking place in a communal lounge. This activity co-ordinator led the activity with enthusiasm and ensured every person was involved. Music was played whilst the activity coordinator gave clues to encourage people to guess who the artist was. Photos were passed around to jog people's memories. People in the lounge enjoyed the activity. We noted they were smiling, singing and tapping their feet.

One relative described the treatment they had received following the death of a family member. They said, "They were marvellous with [family member], so kind, so thoughtful. We were allowed to use the lounge upstairs and we could take as long as we wanted to clear [family member's] room. They (staff) realised we were grieving and understood perfectly."

People and relatives gave us positive feedback and did not raise any complaints with us. The provider had a structured approach to complaints handling. We viewed the 'complaints file' which showed seven complaints had been received. These had been investigated with action taken to resolve the complaint. This included meeting with family members and meeting with health and social care professionals. A separate log highlighted any dignity issues and recurring themes that had arisen from complaints. For example, for one person this related to issues with poor standard of care, weight loss and over sedating. Action had been taken to prevent this happening again including supervision and re-training for staff involved.

Requires Improvement

Is the service well-led?

Our findings

The provider had quality assurance systems in place covering areas such as care planning, medicines, falls and infection control. However, we noted these audits had not always been effective in identifying concerns including some of the issues we found during the inspection. For example, areas relating to a lack of an in-depth falls analysis and inaccurate information in care plans and risk assessments relating to falls management. We noted that information was not always analysed robustly to identify trends and patterns and to ensure learning was used to improve people's safety and wellbeing.

Since our last inspection the provider had employed a new registered manager who had been in post since June 2017. The registered manager told us their priority had been to concentrate on making progress with the action plan developed following our last inspection. For example, building a new treatment room, re-writing nursing care plans, improving compliance with training and increasing staffing levels. They told us they believed there had been an improvement in staff morale so that staff were now happy to come to work. This was confirmed through conversations with the staff team. Staff gave us positive feedback about the registered manager. One staff member told us, "[Registered manager] is firm but fair, approachable. We have a good team." Another staff member said, "I could go to [registered manager] if needed. They are approachable."

People and relatives also gave us positive feedback about the registered manager and said they knew who the registered manager was. They also told us they could approach her with any problems they had. Two relatives said things had improved considerably since the last manager left six months ago. One person commented, "This is our home, it's well managed and I'm happy here." Another person said, "(I have) no complaints. Why would anyone want to complain? We are well looked after, we pick our own food. The food is great and the manager is very approachable." A third person told us, "I have no complaints but if I did the manager would sort it. She is always buzzing about."

People and staff described the home as having a positive atmosphere. One person said, "There is a great atmosphere here, you can have a laugh with everyone…it is really like a family." A staff member commented, "It is a lovely home to work in."

Daily flash meetings were held with the registered manager and other key staff. We attended a meeting during our inspection which was attended by the nurse on duty, a team leader as well as kitchen and maintenance staff. Each staff member gave an update on their plans for that day and shared important information about each person's needs. For example, the chef discussed the menu for the day, the team leader talked about ideas for activities and the nurse provided an update on each person's health and wellbeing. In addition the registered manager told us they did daily walk arounds of the home to check on people's care and wellbeing.

The registered manager was supported by a new regional manager. The regional manager had recently conducted a comprehensive audit of the home. We viewed the report produced following this review which included an action plan to rectify a number of issues the regional manager had identified. Actions identified

were to implement a dependency tool, complete regular reviews of people's care, improving the compliance rate for training and improvements to care records. We found these actions had been completed when we inspected the home.

There were regular opportunities for people and staff to give feedback about the care provided at the home. Bi-monthly meetings were held for people and staff. We saw from reading minutes from the meetings that these were used to communicate important information. For instance, topics discussed at recent residents' meetings included safety in the home, activities and introducing new people to the home. Two people had been to a resident's and relative's meeting. They said it was a positive meeting where everyone discussed how they could make things better. Other areas discussed included what things the provider didn't do so well and how the food could be improved.

Topics discussed with staff were accuracy of care records and maintaining a staff presence in communal lounges. One staff member commented. "We have monthly meetings. We discuss things in the meeting, they listen to us."

The home had recently received positive comments about the care provided at the home. These praised the staff team, meals and the activities available.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to adequately monitor risks to the health and safety of people because the systems to monitor and analyse incidents and accidents were ineffective. Care plans and falls risk assessments were not always accurate. Regulation 17(2)(a), 17(2)(b) and 17 (2)(c).