Caring Homes Healthcare Group Limited

Miranda House

Inspection report

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14 July 2017

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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Miranda House is a care home which provides accommodation and nursing care for up to 68 older people. At the time of our inspection 53 people were resident at the home.

This inspection took place on 13 and 14 July 2017 and was unannounced.

At the last comprehensive inspection in September 2016 we identified the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not being stored at the correct temperature and some tablets had not been disposed of before their expiry date. The provider wrote to us following the last inspection to say they would take action to address the management of medicines by November 2016. During this inspection we found that these improvements had not been made and medicines were still not being stored safely. This was a continued breach of the regulation.

The registered manager had identified that work was needed in relation to storage of medicines and had raised this repeatedly through the provider's reporting processes. Despite this being identified as a breach of regulation at the last inspection, the provider had not ensured that action was taken to store medicines within the safe temperature range. Whilst the quality assurance systems had identified shortfalls, the process to ensure those shortfalls were rectified when the work required additional expenditure or building works was not effective. This had resulted in people using the service being placed at risk of receiving medicines that had been compromised and were not effective.

We observed some positive interactions between staff and people using the service. Generally staff were friendly and the atmosphere was calm and relaxing. We heard staff singing with people and laughing with them. However, we observed some occasions when staff did not respond to people's request for support and reassurance.

Relatives gave mixed feedback about the staff. One said "The managers and the carers are all lovely. They're very caring and loving to me and my relative. They're like my extended family, I love them all". Comments from other relatives included "Some carers are lovely, absolutely wonderful, but others are a bit iffy" and "It's not the Ritz, but I keep my relative here because of certain care staff who are lovely".

Staff were taking suitable action when they identified that people did not have capacity to consent to their care or treatment and had made applications to authorise restrictions on people's liberty. Where restrictions had been authorised with conditions, the registered manager had reviewed the actions they had taken to meet the condition.

Risks people faced were being well managed. Staff had identified risks people faced and had planned with them how those risks should be managed. Staff had a good understanding of the risks and the action that was planned. The plans were regularly reviewed and updated when people's needs changed.

People's records contained care plans relating to their specific needs and there was evidence that the plans were updated when people's needs changed. People and their relatives told us they were involved in developing and reviewing their plans. Where people were not able to tell staff what care they needed, there was a record of who had been involved in making decisions.

Staff told us they received training and support which gave them the knowledge and skills needed to do their job effectively. Comments included "I did the Living in my world training a few weeks ago; it was about putting ourselves in the shoes of people we care for. It was really good" and "I'm doing the Care Certificate". Nurses said they had access to professional development in order to meet their registration requirements.

Staff generally spoke highly of the registered manager. Comments included "If I speak to the manager about anything, she's always there and will listen. She takes the time to listen" and "Our manager is excellent, always on hand to listen". One member of staff said "The manager is better than she used to be, she's more supportive and tries to sort problems out".

We found breaches 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.

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 received the support they needed to take any medicines they were prescribed. However, action was needed to ensure they were always stored at the temperature recommended by the manufacturer.

There were systems in place to manage risks people faced. Staff had a good understanding of the action they needed to take to keep people safe.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people.

Is the service effective?

Good

The service was effective.

Staff understood the action they needed to take if people did not have capacity to consent to their care. The registered manager regularly reviewed any restrictions on people to ensure they were using the least restrictive option of supporting people.

Staff received good training, which gave them the skills and knowledge to do their job effectively.

People were able to see relevant health care professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Generally staff were friendly and the atmosphere was calm and relaxing. However, we observed some occasions when staff did not respond to people's request for support and reassurance.

Staff provided care in a way that usually maintained people's dignity and upheld their human rights. However, one person was not always supported to move to a private space when they undressed themselves.

Is the service responsive?

Good

The service was responsive.

People and their representatives were involved in planning and reviewing their care.

Staff had a good understanding of people's specific needs and provided care and support in line with the care plans.

People told us they knew how to raise any concerns or complaints and most were confident that their concerns would be resolved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post and staff felt they were well supported.

The registered manager had identified shortfalls in the medicines management systems. However, effective action had not been taken to resolve the problems. The continued breach of regulations had not been picked up and resolved by senior managers within Caring Homes Healthcare Group Limited.

Miranda House

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 13 July 2017 and was unannounced. We returned on 14 July 2017 to complete the inspection.

The inspection was completed by two inspectors. We reviewed reports from the last comprehensive inspection in September 2016. This enabled us to ensure we were addressing potential areas of concern. We also looked at the notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send us.

During the visit we spoke with six people who use the service, four relatives and six staff, including nurses and care assistants. We spoke with the registered manager and area manager. 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 spent time observing the way staff interacted with people who use the service and looked at the records relating to care and decision making for eight people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in September 2016 we identified that the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not being stored at the correct temperature and some tablets had not been disposed of before their expiry date. The provider wrote to us following the last inspection to say they would take action to address the temperature of the room in which medicines were stored by November 2016. During this inspection we found that these improvements had not been made and medicines were still not being stored safely

Medicines were not managed safely because they had not been stored within the recommended safe temperature range. There were two clinical rooms where medicines were being stored. On the ground floor we looked at the room temperature monitoring log from January 2017 onwards. The records showed that from January 2017 to May 2017 staff had recorded room temperatures of between 24 and 27 degrees Celsius. The recommended maximum room temperature for the safe storage of medicines is 25 Celsius. In May 2017 an air conditioning unit had been installed and since then the temperature had been logged between 18 and 20 Celsius.

On the first floor, the room temperature monitoring log showed that staff had recorded temperatures above the maximum 25 Celsius on 185 occasions since January 2017. On some days the temperature had been recorded as 29 Celsius. This issue had been raised using the provider's incident reporting system and records showed the registered manager had raised their concerns on many occasions. Despite this, no action had been taken by the provider to rectify the situation and no advice had been sought from a pharmacist to ascertain if medicines were safe to use. We asked the registered manager to contact the pharmacist for advice about whether the medicines were safe to use having been stored at high temperatures for so long. They told us they had been advised by the pharmacist that medicines should only be used if stored outside of recommended temperatures for 24 hours or less. This meant that people had consistently been administered medicines that had not been stored in accordance with manufacturer guidance or in accordance with pharmacist advice.

We looked at the latest pharmacist advice visit, dated 24 November 2016. The pharmacist had documented 'Medicine storage rooms, especially on the first floor are regularly over 25 degrees centigrade. This was an issue during the last visit. Some actions have been taken to address, but still needs more'. Despite the issue being raised during our last inspection, and the feedback from the pharmacist visit, action had not been taken to resolve the issue. Additionally, the provider's own policy was not being followed. The provider's Medicines Management Policies and Procedures stated 'The temperature of the clinical room used for storage of medication should not exceed 25 Celsius and should be taken and recorded daily'.

Following the inspection we received confirmation from the provider that an air conditioner unit had been fitted to the first floor medicines storage room. However, action had not been taken following the last inspection in September 2016 until we highlighted it and the provider had failed to ensure medicines were stored within the correct temperature range.

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

We looked at medicine administration record (MAR) charts. Although there were photographs of people using the service at the front, the majority of these had not been dated and some were old photographs that were no longer a true likeness of people. For example, we saw a photograph of one person with a beard, but they were now clean shaven, and other people had lost weight. Having up to date photographs in place assists staff who might not be familiar with people to identify them correctly when administering medicines.

There were some transcribed entries in MAR sheets which had not been countersigned by another nurse to confirm they had been checked for accuracy. This meant the provider's own policy was not being followed because it stated '[Handwritten] entries must be checked and signed by a second nurse to ensure all details have been entered correctly'.

Several people were receiving their medicines covertly. This is when medicine is 'disguised' within food or drink. Capacity assessments had been completed prior to this taking place and where people lacked capacity best interest decision meetings had been documented. These showed that the GP, the pharmacist, staff and relatives had been involved in the decision. However, the process for reviewing the decision to administer covertly had not been followed. For example, we looked at the records for five people receiving their medicines covertly. Of these, four records showed the decision to administer covertly had been made over six months previously and one had been made16 months previously. This meant that the provider's own policy was not being followed because it stated 'The use of covert medication should be reviewed on a regular basis which should be at least every six months'.

We observed part of a medicines round during the inspection. Staff administering medicines knew people well and knew what they had been prescribed and why. They didn't rush people and ensured people had a drink to hand. They asked people if they needed any additional medicines, such as pain relief.

The MAR charts we looked at had all been signed to indicate that people had received their medicines as prescribed. Topical medicine administration charts however, had not always been signed. Although we looked at some that had been completed in accordance with the prescription, others had not. For example, one person had been prescribed a cream 'to be applied during personal care', but the chart had not been signed for five days during July.

Protocols were in place for when people might require additional medicines. These were detailed and person centred and included guidance for staff such as how people might appear if in pain if they were unable to communicate this to staff. When administered, the reasons had been documented which meant it was easy for staff to identify any trends.

We assessed the care files of eight people using the service. Each person had a set of assessments covering the risks they faced and the action staff should take to manage those risks. The assessments had been regularly reviewed with people and their representatives and changes had been made to the management plan where necessary. People had risk assessments in place for areas such as falls, mobility, skin integrity and nutrition. When risks had been identified, the care plans contained clear guidance for staff on how to reduce the risks. These included details of any moving and handling equipment that was required to move people safely. Some people were at risk of falling from bed and in these cases bed rails risk assessments had been completed prior to being used. Additionally staff had documented further details in relation to when some people might be at more risk of falling. For example, in one person's plan it had been documented "More prone to falls in the evening when being assisted to bed as can become agitated when tired". When

the outcome of risk assessments indicated that bed rails were not appropriate, less restrictive methods of keeping people safe were used; for example, the use of high/low beds and crash mats.

Some people had been assessed as being at high risk of developing pressure ulcers. In some instances, air mattress and pressure relieving cushions were being used to relieve the pressure on people. When we checked, these were in place and were at the correct setting. Additionally when care plans directed staff to change people's positions regularly, position change charts had been completed in accordance with the plans.

We received mixed feedback regarding staffing levels. All of the staff we spoke with said they felt there were enough on duty to meet people's needs. One said "Even if someone goes off sick, we pull together to make it work". Visitors to the service gave mixed responses. Comments included, "I think there's enough staff. They're always busy, but they make the time"; "There are generally enough staff. Sometimes they're a bit rushed but [my relative] always gets the care he needs"; "I've always said there isn't enough staff" and "There isn't enough staff on duty. People are left on their own a lot". At times during our inspection we had to locate a member of staff to assist people because staff were busy elsewhere. Following the inspection the registered manager told us they had secured additional funding to provide one to one care for a person whose needs had increased and needed more support from staff.

The registered manager used a dependency tool to assess the level of staff that were needed. This had been reviewed regularly and had resulted in changes to staffing levels when assessed to be necessary. The home's staff rota demonstrated the assessed levels of staff had been provided, with gaps in the rota being filled by staff completing extra shifts or the use of temporary agency staff.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We checked the records of two recently recruited staff and found these procedures had been followed.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. They said they would report abuse if they were concerned and were confident managers would act on their concerns. Staff were also aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with. We saw that the provider was working with the safeguarding team to respond to concerns where they had been raised.

During the inspection we observed staff using appropriate protective equipment, such as disposable gloves and aprons. Staff were aware of the infection control procedures in place and said they were followed by all staff. We observed staff following the infection control procedures. The management team completed regular infection control audits to assess how the procedures were being put into practice.

Good

Is the service effective?

Our findings

At the last inspection in September 2016 we identified improvements were needed to ensure that conditions made when restrictions were authorised were complied with. During this inspection we found these improvements had been made by the provider.

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 legally authorised under the MCA. 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 are called the Deprivation of Liberty Safeguards (DoLS).

Staff had taken appropriate action where they assessed that people did not have capacity to make a decision. Staff had completed training in the MCA and DoLS and those we spoke with had an understanding of the principles of the Act. People's care records contained detailed and decision specific mental capacity assessments and the provider had made DoLS applications to the local authority where appropriate.

Some of the DoLS authorisations contained conditions that the provider was required to meet. The registered manager kept a record of all DoLS authorisations and they were regularly reviewed to ensure conditions were being complied with. The reviews included assessing whether they were using the least restrictive option of supporting people.

People's records contained copies of any power of attorney documents that people had in place. A power of attorney has legal authority to act on a person's behalf in some circumstances and can relate to decisions about finance or the person's health and welfare. Details of these powers were included in people's care plans. Where there was no power of attorney in place, staff had made decisions in people's best interest, following consultation with a range of people, including families and professionals.

At the last inspection in September 2016 we identified improvements were needed to ensure the environment was suitable for people and fire doors closed effectively. During this inspection we found these improvements had been made by the provider. Fire doors closed properly when they were released from their retaining device. A bathroom that had a hole in the floor covering at the last inspection was no longer being used. The bathrooms that were being used were clear and free of clutter.

Most people and relatives told us they received good care and support from staff. Comments included, "They provide the care that I need" and "They're very good. I can't fault them. [My husband] always gets the care he needs".

Staff told us they received training and support which gave them the knowledge and skills needed to do their job effectively. Comments included "I did the Living in my world training a few weeks ago; it was about

putting ourselves in the shoes of people we care for. It was really good" and "I'm doing the Care Certificate". Nurses said they had access to professional development in order to meet their registration requirements. For example, one nurse said "I've just completed practical first aid and Understanding my world – which is the next level course after Living in my world". Additionally, staff said they had regular supervision sessions with their line manager. The registered manager had systems to track the training and supervision staff received, and ensure any gaps were addressed. Staff told us they felt well supported and were able to raise issues or concerns at any time with a member of the management team.

People were supported to have enough to eat and drink. Nutritional assessments had been completed and when risks of dehydration or malnutrition had been identified, the plans detailed action that was required from staff. People's weights were monitored and when people lost weight, records showed that GP advice was sought. Plans showed that people had been prescribed nutritional supplements and that referrals were made for specialist advice, such as the dietician or speech and language therapist. People's nutrition plans were person centred. For example, in one plan it had been documented "Doesn't like bits in food and so has a puree diet" and "Needs assistance with meals – prefers to be assisted with a spoon". Some people were having their food and fluid intake monitored. In these cases, all of the charts we saw had been completed in full. In addition, daily records showed that staff were aware of people's intake and documented any concerns.

We observed lunch during our inspection. Staff assisted people who needed support. They spoke with people as they assisted them, informing them what the food was and asking if they were ready for more. Generally, we observed staff assisting people respectfully, sitting alongside them. However, on one occasion we saw one member of staff sitting between two people and assisting both with their meal at the same time. On another occasion we observed another member of staff stood over someone whilst assisting them with their lunch. Both of these instances demonstrated a lack of respect for the people they were supporting. We discussed these issues with the registered manager who said the concerns had been addressed with individual staff members following our feedback.

People were offered drinks throughout the day. We observed staff making people hot and cold drinks when they requested them and encouraging people to drink enough to stay hydrated. Some people chose to eat in their rooms or in one of the lounge areas rather than the dining room. Visitors to the service spoke highly of the food. Comments included "The chef here is amazing" and "The food is lovely, my relative really enjoys it". Three of the visitors we spoke with said they liked to visit at meal times in order to assist their relative. The food looked and smelt appetising. We saw that people had a good choice of options available, including a cooked breakfast in the morning and a choice of two main meals at lunchtime.

People had access to on-going healthcare. Records showed that people were reviewed by the GP, the hospice team, dietician and the memory clinic team. Wound assessments showed staff appropriately sought the views of the tissue viability nurse and plans of care were put in place and followed. Most relatives were happy with the support provided, with comments including, "When my relative has been ill, they (the staff) are on the ball. They ring the GP and let me know immediately" and "They always call me if there's a problem or he's unwell. However, another visitor said they had been contacted when their relative had a fall, but the communication from staff had not been clear and they did not know how they had fallen.

Requires Improvement

Is the service caring?

Our findings

We observed some positive interactions between staff and people using the service. Generally staff were friendly and the atmosphere was calm and relaxing. We heard staff singing with people and laughing with them. However, on one occasion we overheard one person calling out, sounding upset. They were calling "Mum" repeatedly, and when a member of staff walked past and asked if they were ok, they said "I want my mum". However, the member of staff walked past them and didn't offer reassurance or support. On a separate occasion, a different person called out "Please help me, please help us". A new member of staff who was completing a shadow shift heard the person and told an established staff member who had left the room. None of the staff returned to the person to find out what the problem was or offer any reassurance.

Despite this, generally we observed staff being kind and gentle with people. When the activities co-ordinator entered the lounge they entered singing. They then took the time and to go and say "good morning, how are you" to each person individually.

One person using the service said "I haven't been here long, but the staff all seem ok" and "I said I fancied a pint and they went and bought me some cans of bitter". However, the same person had been using the service for over a week and said they really wanted a shave but didn't have a razor. Staff had documented in the person's daily notes five days earlier "Unable to shave as has no razor or foam", but nobody had found shaving equipment for them. When we discussed this with a member of staff, they said they would arrange for this to happen.

Relatives gave mixed feedback about the staff. One said "The managers and the carers are all lovely. They're very caring and loving to me and my relative. They're like my extended family, I love them all". Comments from other visitors included "Some carers are lovely, absolutely wonderful, but others are a bit iffy" and "It's not the Ritz, but I keep my relative here because of certain care staff who are lovely".

Staff spoke positively and passionately about their roles. Comments included "We're passionate about residents and their families. It's a lovely home. At the end of my shift I honestly know I've done a good job", "The staff here are very connected to people. We know the residents and understand them" and "It's like I'm looking after my own family. It's not just a job, I care about these people". One said "I go home at night feeling people have had good care. The care staff are really very good".

People's privacy and dignity was not always maintained. Although personal care took place behind closed doors and although staff told us what they did to maintain people's dignity, we saw episodes during lunch when people were not treated with dignity. Additionally, on several occasions we observed one person walking along the corridor with no clothes on or with their clothes undone. Each time this happened, we had to find a member of staff to assist the person in order to help them get dressed, although when staff did assist the person they did so kindly and respectfully.

People were supported at the end of their life to have a comfortable and dignified death. During our inspection, one person was nearing the end of their life and staff had asked for specialist support from the

local hospice team. We saw that the family of this person was welcomed and supported to stay with their relative for as long as they wanted to. Additionally, we saw that the person's spiritual needs were met by a visit from a priest.

People were supported to contribute to decisions about their care and were involved wherever possible. For example, people and their representatives had regular individual meetings to review how their care was going and whether any changes were needed. Details of these reviews and any actions were recorded in people's care plans. People and their relatives told us staff consulted them about the care they received and their preferences.

Good

Is the service responsive?

Our findings

Care plans were person centred and where possible people using the service or their advocates had contributed to them and been involved in the review process. All of the plans we looked at had been reviewed regularly. However, we also looked at the plan for one person who was at the service for respite care. They had been admitted eight days previously, but although there was a "short stay" plan in place, it had not been filled in. Despite the lack of written information available, staff demonstrated a good understanding of the person's needs.

The plans contained details of people's personal life histories which meant that staff were able to learn more about people's lives prior to them moving to the service. One visitor said "The staff listen to me when I tell them about my relative and they add it to the care plan".

The plans detailed how people preferred to receive support from staff. Communication plans in particular were very detailed and responsive to people's needs. For example, in one person's plan who had mental health needs, the personal profile section detailed all of the things that helped the person to communicate their needs during periods of distress, including triggers that may cause these episodes.

In another person's plan it had been documented that they were prone to feelings of frustration and how staff should support them with this. For example, the plan guided staff to 'speak in a calm and clear manner' and 'better in 1:1 situations'. The same person's plan in relation to their personal care was also detailed, for example 'Likes music on whilst washing, likes talc and some spray when dressed'. Another person's plan detailed how they preferred staff to style their hair and the jewellery they liked to wear.

Some people using the service had wounds. Wound care plans were detailed, had photographs in place and described the appearance of the wound at each dressing. When required, tissue viability nurse support had been sought.

Visitors said they had opportunities to attend resident and relative meetings. One said "They have meetings regularly and I'm planning to go to the next one. I think it's important to get involved". However, another visitor said "They're not well frequented and if you speak up things don't always get acted on. I gave up going after two or three because nothing gets done".

The service had a complaints procedure and we saw there was a record of complaints received. Individual complaints had been responded to by the registered manager and details of complaints were reported through the home's monthly management returns. Complaints were also reviewed by the regional manager as part of their monthly visits to the service. People using the service and relatives said they knew how to complain. One relative said they had complained in the past and didn't feel as though their complaint had been resolved. Another relative said "I would speak to [the registered manager]. I've spoken to her about a few issues and she has always sorted them out. She's very good". Other visitors commented "I've never had to complain, but if I did I would go to the nurse on duty. They're wonderful and I know they would sort it".

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager completed a monthly assessment of the service and any areas where improvements were needed. A regional manager visited the service regularly to complete reviews of the way the home was working. These reviews included assessments of incidents, accidents, complaints, training, staff supervision, the environment and external reports, for example, from their supplying pharmacist or environmental health officers. Any actions from these reviews were collated for the registered manager and updated each month to report on progress in meeting them.

The registered manager had identified that work was needed in relation to storage of medicines and had raised this repeatedly through the provider's reporting processes. Despite this being identified as a breach of regulation at the last inspection in September 2016, the provider had not ensured that action was taken to store medicines within the safe temperature range. Whilst the quality assurance systems had identified shortfalls, the process to ensure those shortfalls were rectified when the work required additional expenditure or building works was not effective. This had resulted in people using the service being placed at risk of receiving medicines that had been compromised and were not effective.

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

Accident and incident forms had been completed with detailed information. The forms included actions from the registered manager as part of their review of the form. This helped to ensure that incidents and accidents were fully investigated and actions taken to reduce the risk of them happening again.

The registered manager completed a daily 'walk around' in the service. This was used to assess how the home was operating. There were reports of their observations and details of any actions that had been taken to address shortfalls that were identified. The management team held a heads of department meeting every morning. This was used to review what had happened overnight and plan any work that was required to ensure the service operated effectively.

Staff generally spoke highly of the registered manager. Comments included "If I speak to the manager about anything, she's always there and will listen. She takes the time to listen" and "Our manager is excellent, always on hand to listen". One member of staff said "The manager is better than she used to be, she's more supportive and tries to sort problems out".

The registered manager told us her management style was to be open and honest and to learn from mistakes to ensure the service moved forwards. The registered manager said she was passionate about

supporting staff to develop their skills and knowledge. The registered manager was working with an Alzheimer's support group to make the service more accessible to people in the local community. There were plans to establish an arts group that will be open to everyone locally. This had come about after they held a 'Living in my world' information session in the service that was open to anyone who was interested.

Satisfaction questionnaires were sent out regularly asking people their views of the service. We saw actions had been taken in response to people's feedback, for example changes to menus.

There were regular staff meetings, which were used to keep staff up to date and to reinforce the values of the organisation and how they expected staff to work. Staff also reported that they were encouraged to raise any difficulties and the registered manager worked with them to find solutions.

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 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured systems to assess the quality of the service provided resulted in necessary improvements. Regulation 17 (2) (a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured the proper and safe management of medicines. Regulation 12 (2) (g).

The enforcement action we took:

We served a warning notice on the provider.