The Orchards Residential Care Home

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Inspection report

The Orchards Mill Lane
Bradwell
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Tel: 01493652921

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 October 2017 and was unannounced.

At our last inspection in July 2016, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This was because robust systems were not in place to identify risks to the service and individuals. At this inspection carried out on 10 October 2017, we found that the service had implemented an environmental audit to monitor risks that may occur in the building, but that this had not been wholly effective. Other quality audits had also failed to identify the areas we found as requiring improvement. This means the provider remains in breach of Regulation 17. You can see what action we took at the back of the full version of the report.

The Orchards Residential Care Home is registered to provide accommodation and personal care for up to 13 older people, some of whom may be living with dementia. At the time of our inspection there were 12 people using the service.

There was 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.

A provider audit had been implemented to take account of environmental risks, but had not identified all risks. There was now a legionella risk assessment in place and control measures to monitor the water system. Other quality audits the service was carrying out had failed to identify areas which we found as requiring improvement. The service was not analysing falls data in detail as a method of identifying any trends.

The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia, and we have made a recommendation about this.

Staffing levels were meeting people's physical needs; however, we have requested that the current arrangements are reviewed to ensure that staffing levels cover both the routine and emergency work of the service.

The registered manager had applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. However, Best Interests processes were not fully understood, and we found documentation was not completed correctly.

Systems were in place for managing medicines and people received their medicines in a timely manner. However, where people were having medicines as required, or at a variable dose, improvement was required to ensure it was clear what had been administered and why.

Risks were identified, assessed and managed. However, we found that the level of information documented in certain areas needed to be more detailed to ensure that staff had up-to date and clear guidance to help them support people safely.

Activity provision was provided by care staff. Feedback from some people and their relatives indicated that the current provision of activity was not always meeting individual or specialist needs.

Staff respected people's privacy and dignity and interacted with people in a caring, respectful and professional manner. Systems were in place which safeguarded people from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

People and relatives said if they needed to make a complaint they would know how to. There was a complaints procedure in place for people to access if they needed to. The views of people, relatives, professionals and staff were sought via an annual survey.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The culture in the service was welcoming, friendly, and person-centred. The management team presented as open and transparent throughout the inspection, seeking feedback to improve the care provision.

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 consistently safe.

Systems were in place for managing medicines and people received their medicines in a timely manner. However, documentation and safe storage of certain medicines required improvement.

Staffing levels were meeting people's physical needs; however, we have requested that the current arrangements are reviewed to ensure there is adequate staffing should emergency situations arise.

Risks relating to the environment had been assessed; however, we found some furniture needed to be secured to the wall to prevent an accident.

Risk relating to falls needed to be more detailed within care plans.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were asked for their consent before any care, treatment or support was provided. However, the Best Interests decision process was not implemented correctly or fully understood by the registered manager.

Staff received training relevant to their role and were encouraged to
continue their learning.

People were supported to maintain good health and had access to healthcare support in a timely manner.

People's nutritional needs were assessed and professional support was obtained for people when needed.

Is the service caring?

Good

The service was caring.

Staff were kind and attentive to people's needs.

People were supported to see their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activity provision was not at a level which would meet the individual and specialist needs of all people using the service.

The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia.

There was a complaints procedure in place. People and relatives knew how to complain.

Care records were updated in line with people's changing needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The auditing system in place to monitor the quality and safety of the service had not identified the areas we found as requiring improvement. Falls data was not being analysed in detail.

There was an open and transparent culture in the service. Staff felt able to voice their opinions and had confidence in the management team.

The Orchards Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on 10 October 2017, was unannounced and undertaken by one inspector and an expert-by-experience. 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 our 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. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law.

Some people living in the service were living with a condition which meant they were unable to give their views about the service in any detail; however, we were able to speak with four people living at the service, and four relatives. We spoke with the registered manager and provider, and three members of care staff. We also observed the interactions between staff and people. Following the inspection we spoke with two health professionals.

To help us assess how people's care needs were being met we reviewed three people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in July 2016, we found environmental risks that could pose a risk to people's safety or welfare. This included the absence of window restrictors, on the first floor, which could put people at risk of a fall from height. At this October 2017 inspection we found that all windows on the first floor had since been fitted with restrictors.

At our previous inspection we also found that there was not a legionella risk assessment or adequate control measures in place to minimise the risk of legionella bacteria in the water system. At this inspection we found that the service had implemented a risk assessment in consultation with environmental health officers who had visited the service. Water temperatures were being monitored, along with descaling of taps and shower heads, and monitoring of infrequently used outlets, all of which will reduce the risks associated with the growth of legionella bacteria.

The previous inspection identified that personal care items (such as toothbrushes and face cloths) were being stored on toilet cisterns, which presented a significant risk of cross contamination. At this inspection we found personal care items were stored appropriately in people's rooms. Commodes which were previously found to be old and worn had been replaced.

Systems were in place for managing medicines and people received their medicines in a timely manner. We saw that medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines. One person told us, "They [staff] always make sure that I get my tablets on time each day." A relative said, "[Relative] gets all medication on time which is important as they have high blood pressure, and gets very agitated and the medication has calmed them down."

People were supported to take their prescribed medicines. However, we observed during the lunchtime medicine round that one person's medicines had been put in a plastic pot and left with the person in a communal area. The staff member returned 15 minutes later to remove the pot. The person was observed by us taking the tablets, but not by the staff member, meaning they could not be sure the person had taken them. There was also a risk that these medicines could be removed inappropriately or there was the potential for someone living with dementia to take these in error.

For people receiving medicines 'As required', there were no protocols in place for staff to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling, and would provide staff with information, such as symptoms a person may display if they were in pain. One person was prescribed medicines for agitation, but there was no clear information on interventions which may work to reduce the agitation before the medicines were considered. Following the inspection, the registered manager advised us they had implemented a protocol for all people on 'as required' medicines. This will reduce the risk of medicines being given when they may not be needed.

Where people were receiving a variable dose of medicine (one or two tablets), we found on three MAR charts that the entries were not clear. We could not determine what medicine had been taken, as the entry was not

legible. We brought this to the attention of the registered manager who advised us that staff should be writing this on the back of the MAR chart, and would remind staff of this.

Some people were receiving topical applications, such as creams. However, there were no body maps to instruct staff on where the cream should be applied. We discussed this with the manager who confirmed following the inspection that these were now in place. We also found that creams were not stored securely. We discussed this with the registered manager who advised us they would address this promptly.

Risk assessments provided staff with guidance on how risks to people are minimised. Risk assessments were completed in relation to the risk of developing pressure ulcers, nutritional risks, moving and handling and mobility. However, some risk assessments contained generic wording. For example, where people were at risk of developing pressure ulcers, the same phrasing was used in each assessment; 'to inspect skin daily/weekly, and review mattress and seating and repositioning schedule'. Whilst we found that relevant equipment, such as pressure relieving mattresses and cushions had been provided to people, their care records did not reflect this. Additionally, staff were not recording that skin had been checked in the daily notes as it was not clear in care plans if this was daily or weekly. Following the inspection the registered manager told us each care plan had been reviewed and amended to ensure information was clearer.

Risks in relation to falls needed to be more detailed within people's care plans. Whilst falls were referred to in people's mobility assessments, a separate care plan should be in place which details particular risks and how these were being managed to reduce further falls. The specialist falls team had recently visited the service and given advice in relation to this.

Risks to people injuring themselves or others were limited because equipment, including hoists and electrical/fire equipment had been serviced and checked so they were fit for purpose and safe to use. People's care records described what help they would need in an emergency situation if they had to evacuate the building promptly. There was also a fire sledge on the first floor which could be used to assist people to evacuate quickly.

We asked people if there were enough staff to meet their needs. One person said, "I feel safe here even though I keep falling over. My legs just seem to go from under me. Thankfully the girls [staff] are there to hold me. Thankfully there is always someone around if I need any help."

The registered manager told us that they could flex staffing levels if required, and had received no feedback to indicate that staffing was not sufficient. We advised them to review the current arrangements to ensure that staffing levels covered both the routine and emergency work of the service. For example, if a person was to fall on the late shift and two staff needed to attend to the person, there would be no other staff available to monitor the welfare of other people. The provider told us that emergency cover could always be arranged if needed.

Staff working in the service felt staffing levels were adequate. One staff member said, "Three carers in the morning is fine, it runs ok. We have two staff on the late, and this is also ok as people like to go to bed at different times. If we hear a pressure mat alarm, we attend very quickly." Another said, "There is enough staff, we work well as a team. [Registered manager] would go mad if we didn't." A third said, "I think there is enough staff. We are not rushing around, and we are an established team. Staff have worked here for years."

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "There are contact numbers around for safeguarding teams, you will see them on the wall. I would call them if I was

worried." Another said, "I'd report any concerns of abuse to [registered manager], I've got the number for outside safeguarding teams if I need it." A relative said, "My [relative] seems happy and safe here and I have no concerns. If I did I know I would just need to speak to the manager and things would be sorted."

Safe recruitment procedures were in place. We looked at the recruitment records of three staff, which showed appropriate background and identity checks had been carried out. These included contacting former employers for references and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about people who may be barred from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

At the last inspection we found that where people had a Lasting Power of Attorney (LPA), it was not always recorded in their care records whether this was in relation to the person's finances, or their health and welfare. At this inspection we found improvement in this area. Records detailed what legal authority LPA's held which ensured any decisions made on the person's behalf were lawful.

The registered manager had made five DoLS applications and were awaiting the outcome of these applications. They had a good understanding of what constituted a deprivation of liberty, and had a log of when the DoLS had been applied for and had followed up those made over one year ago. We advised that there was not a requirement to follow up applications previously made, only where there had been a change in a person's situation.

Where people required decisions to be made in their best interests, there appeared to be less of an understanding of when this might be necessary. For example, one person had been assessed as having capacity, but had a best interests decision in place for a pressure mat (which alerts staff if the person stands up). Another person had a best interests decision in place because they shouted which disrupted other people living in the service. We were not clear what decision was being made in their best interests, and if it was related to the person shouting, this would not necessitate a best interests decision. Where best interests decisions were in place, a mental capacity assessment had not always been completed first to demonstrate the person lacked capacity.

We saw some examples where appropriate tests of capacity and associated best interests decisions had been undertaken. For example, where one person was a diabetic, but liked to eat sugary snacks, and where another person had a bed rail in place to ensure their safety. We therefore asked the registered manager to review all best interests decisions which were in place, and to ensure they had an associated mental capacity assessment.

Staff demonstrated regard for people's choices and were observed always seeking permission before acting for them. One staff member said, "It is important to get consent from people if you are helping them. If it's important we [staff] try and encourage them and explain the importance of the task, but if they say no, we

leave them and come back later. We [staff] know people well here so that helps." Another said, "Most people here can consent to a certain degree, like day to day decisions, such as what to wear. If they can't we make choices for them, and we consult with family members." We observed two staff helping a person to their dining room chair; they allowed the person the opportunity to decide where they wanted to sit without any coercion. It took over 15 minutes to sit the person at the table, but this approach enabled them to be in control of the situation.

At our previous inspection in July 2016, we observed that people had choice about what they ate, but often appeared unsure of what they had chosen at lunchtime, and that people would benefit from a pictorial aid. At this inspection the registered manager showed us that they had devised a folder containing pictures of food which people could select from. This helped people living with dementia to identify certain foods they enjoy more easily. However, there was not a menu displayed in the dining room, should people wish to remind themselves what was on the menu for the day.

People were supported to eat sufficient amounts and maintain a balanced diet. People told us they enjoyed the food. One person said, "I like the food that I get here and I'm looking forward to today's lunch as it's one of my favourites." Another said, "The food is very nice here and I really enjoyed it as you can see, I cleared my plate".

We observed the lunchtime meal. There was a dining area where five people sat to eat their lunch. It was a small room, and if everybody chose to eat in the dining room there would not be sufficient space. Four people chose to eat in the lounge area and others in their own rooms. The lunchtime experience was practical and the atmosphere calm. Staff were available for people who required assistance.

Where people required their foods to be supplemented due to weight loss, we saw that this was done, and advice given by dieticians was being followed.

People told us they felt that staff were trained to carry out their role. One person said, "The carers certainly know what they are doing, particularly when they help me move about the home and have a lot of patience because I am not that quick. They always try to make sure that I'm happy and will help me go outside." Another said, "I suppose they [staff] are well trained. They seem to know what they are doing for me. They always ask me what I want before they do anything." A relative said, "I think they [staff] know what they doing when they care for our [relative]. They always make sure that they ask before they do anything for them."

Staff received training in areas relevant to their role. This included safeguarding, medicines, first aid, pressure care, diabetes, end of life care, dementia and basic life support. One staff member said, "We [staff] have competency checks which the manager does, to make sure we are doing our jobs properly. [Registered manager] observes me doing the medicines round." Another said, "I discuss any training needs in supervision."

Staff received supervision sessions which provided staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "We have supervision every eight weeks." Another said, "We [staff] get supervision regularly. We can discuss anything really, it's good."

Staff new to the service completed an induction, which consisted of mandatory training and shadowing of more experienced staff. One staff member said, "I had a good induction. I did my training. I shadowed staff and read all of the care plans." If staff did not hold relevant qualifications in care, they were expected to

complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. This included dieticians, GP's, falls teams, community nurses and dementia support teams. One person said, "The doctor comes each week and it's always the same one which is really nice. If I need to see them I just to need to ask and it will happen." Another said, "If I need the doctor I can see them at any time and the district nurses keep an eye on my leg." A relative said, "What is very good is the GP who comes in every Wednesday, which we are happy about." A health professional said, "I have no concerns at all about this home. They know all the residents well, they are forward thinking and plan ahead."

The registered manager told us they were in the process of arranging monthly meetings with the community nurse to discuss people who may need to be seen, and therefore identifying any health issues as early as possible.

Good

Is the service caring?

Our findings

At our previous inspection in July 2016, we made a recommendation that the provider seek advice to ensure they were acting in accordance with relevant legislation and best practice regarding the use of closed circuit television (CCTV) which could impact on people's privacy. At this inspection we saw that the service had implemented a policy and procedure in relation to the use of CCTV. However, following this October 2017 inspection, the provider told us they were not routinely reviewing the footage, and therefore made the decision to disconnect the CCTV from all areas of the building.

People told us that staff were kind and caring. One person said, "Of all the homes I have been in this is the best. The girls [staff] are generally good at being there to help you." Another said, "The care the staff give is very good and they are always prepared to help you. They always speak nicely to me and never raise their voices which I really like and we can always have a good laugh." A relative told us, "The care my [relative] gets is very good and I know that they can get agitated but they [staff] deal with that very well. They always do everything with a smile which makes a difference."

We observed that staff had good relationships with people, and were patient when supporting people with their care. Many of the staff had worked in the service for a long period of time, so knew people well. This helped to anticipate people's needs and provide continuity of care. People readily asked for assistance from staff, and the atmosphere was relaxed.

People's care plans made reference to people's individual preferences in relation to how they liked their care delivered. Where people were unable to contribute to the planning of their care, family members and advocates had been consulted. One relative said, "I have seen [relatives] care plan and they keep us abreast of any changes that are happening." The importance of encouraging people's independence was also referred to in care plans, including where people may need support from staff to initiate and complete tasks. Staff respected people's privacy, and we saw that staff were discreet when supporting people with tasks such as assisting them to use the toilet. One staff member said, "We always respect people's privacy. We close curtains and doors if we are carrying out personal care."

Resident meetings were held and well attended. We reviewed the minutes of the meetings which showed that people were asked their views about the food, activity provision, and quality of their care. Relatives told us that they were always made to feel welcome when they visited and that they could visit at any time. This meant that people were able to socialise with family and friends as they chose and this reduced the risk of social isolation.

People's 'last wishes' were referred to within their care plans, however, we found that some phrasing was generic in several care plans. The registered manager informed us that all staff had received end of life training, and they had received information from the GP regarding advanced care planning, and that this was an area they were planning to develop.

Requires Improvement

Is the service responsive?

Our findings

The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedroom. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

The majority of people spent their time in the main lounge. The lounge was the size of an average domestic house and was crowded with chairs and tables. There was an adjoining room which was much smaller and had a low sofa which was not appropriate for people with reduced mobility to use safely. This room contained a piano and a large book case with a selection of books, and also acted as a store for four wheelchairs. The provider had not considered how this room could be utilised to provide more space for people or develop a sensory area that people could enjoy away from the main lounge.

We recommend that the service explores current guidance from a reputable source, (such as the Social Care Institute for Excellence) in relation to improving the environment for the benefit of people living with dementia.

There was not a dedicated activity co-ordinator in the service. The registered manager told us that care staff provided activity to people, but often people would not be motivated to join in. The provision of activity was limited to when staff were available, usually in the afternoons. One activity observed involved people hitting a balloon back and forth with a fly swat, which some people did not appear to be stimulated by.

Some people and their relatives told us that they were happy with the activity provided, and some people did not wish to join in. The registered manager told us how they had organised garden parties in the summer which people really seemed to enjoy, along with an Elvis impersonator which had been well received by the majority of people in the service and they were therefore securing other dates for them to visit.

However, in response to day to day activities which took place in the service, one person told us, "We [people] don't do a lot here and I would like to do more in the day to keep my mind active. Television is so boring. Another said, "I would like more activities with a bit more challenge. We spend hours each day with nothing to do; it's a waste of time." A third said, "I would like some different activities. We did a couple of nice garden parties this summer which was really nice."

A relative said, "Another television or a radio in the quiet room would give them a change of scenery." Another told us, "I think all the staff are approachable, but they could have more things to do and more trips out." A third said, "The care our [relative] gets here is good, but more activities would help as they don't do lot all day and they don't move around. The lounge and the quiet room could be better. Before their recent

illness they were more independent but not now. A day trip would be nice for them, but there is not enough staffing to do that."

People's care plans guided staff in the care that people required and preferred to meet their needs. This included personal care, nutrition, continence, mobility, and night time routines. Staff regularly updated care plans, including daily records and food and fluid intake as required. Good examples included how people liked their personal care delivered, their personal preferences, and other important details such as wanting to remain independent and how staff could support them to do so.

The service had a complaints procedure for people, relatives and visitors to raise concerns. However, this was not displayed in the service so people knew who to contact if they had a concern. Following the inspection, the registered manager confirmed with us that this had been implemented. People and relatives told us they felt comfortable to raise a complaint if they needed to. One person said, "Any issues, I speak with the manager." A relative said, "I have not complained about anything, but if I needed to I would go to the manager."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in July 2016, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This was because robust systems were not in place to identify risks to the service and individuals. At this inspection carried out on 10 October 2017, we found an audit had been implemented to identify environmental risks; however, this and other quality audits had failed to identify the areas we found as requiring improvement. This means the provider remains in breach of Regulation 17.

At this inspection we found a 'provider audit' had been implemented which took account of the building and any associated risks. This included checking internal and external areas of the building, ensuring there were no obstacles or unnecessary clutter in the communal areas of the service, how staff interacted with people, and the quality of care plans and MAR charts.

The audit carried out in October 2017, found that one fence panel needed to be replaced at the front of the building, the communal garden needed tidying, and that the kitchen ceiling was in need of re-decorating, all of which were being addressed. It did not however identify that some wardrobes in people's bedrooms were unsteady and not secured to the wall, which posed an accident and injury risk. It also did not identify the concerns we found with risks assessments, MAR charts, or that there were no protocols in place for medicines taken 'as required'. The monthly medicine audit had also failed to identify these issues.

Our previous inspection in July 2016, found that the registered manager regularly reviewed accident and incidents which occurred in the service, particularly in relation to falls. At this October 2017 inspection we found that this was not the case. We saw that for the month of September 2017, there had been an increase in falls. The registered manager was able to tell us what had been implemented to reduce the risk of further falls (such as pressure mats which alert staff when a person stands up) and we saw that several people had been referred to specialist falls teams. The electronic records system enabled them to have oversight of all accidents and incidents which had occurred in the service. However, we found that they were still in the process of reviewing falls for the previous month to identify any themes or trends. This information was not being recorded as an additional audit; rather the registered manager had written a few notes on the total number of falls overall for their own information. Data relating to falls needs to be analysed in detail to identify any trends, such as the time of day a person is most likely to fall, and this was not being completed thoroughly.

The registered manager had not ensured that best Interests decisions were implemented correctly, and their knowledge in this area required clarity. Documentation was incorrectly completed, and not always assessed in line with the Mental Capacity Act 2015.

Night staff were carrying our checks to ensure that communal areas were clean, however, there was no documentation in relation to what they were checking and what the findings were.

We saw that the provision of activity had been discussed in the residents meeting, and some people has said

that they did not always feel like playing games, however, it was not clear whether other options, such as sensory stimulation, had been considered or tried. Given the feedback we received, we could not be assured that activity provision was meeting people's individual and specialist needs, which the registered manager and provider had not independently identified.

All of the above constitutes a continued breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Other audits included dining experience, infection control, daily room cleaning checklists, commode and mattress audits, and a management audit, which checked various areas such as staff adhering to the use of personal protective equipment, laundry, cleaning aids, and disposal of waste and sharps (used needles).

The culture in the service was welcoming, friendly, and person-centred. Staff showed a good understanding of their individual roles and spoke with each other throughout the day as to what was happening and what needed to be done.

Staff spoke highly of the registered manager. One staff member said, "[Registered manager] gives me confidence, I could go to them for anything. I think the service is very well run." Another said, "[Registered manager] is lovely, she will sort out any problems quickly, and consults with us [staff] on different things so we all know what's going on." A relative said, "I think my [relative] is happy here. I find all the staff very approachable and I think it is well run and organised." Another said, "It's like a real home. The place is convenient for me and there is a good atmosphere here. I think the home is run well." A health professional told us, "[Registered manager] is on the ball. Sometimes they make me think about what I am prescribing, and if there is a better option."

We saw that annual satisfaction surveys had been issued to people, relatives, staff and professionals for their feedback. These showed positive comments including, "Always friendly and helpful", and, "Residents happy and content."

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 Auditing processes had been ineffective at identifying areas requiring improvement. Not all risks were being analysed sufficiently. 17 (1) (2) (a) (b)