Friends of the Elderly

Orford House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Orford House Residential Care Home 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. Orford House Residential Care Home provides personal care to people. The service does not deliver nursing care.

At our last inspection in August 2015 the service received an overall rating of Good.

Orford House Residential Care Home accommodates up to 29 older people in one adapted building. 24 people were living in the service at the time of our inspection. People had individual bedrooms, three of which had en suite facilities.

The service 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.

People were not protected by the readiness of staff to respond as planned in the event of an emergency. The service had not complied with its policy to undertake building evacuation drills and staff were not clear what the provider's evacuation plan was.

There were sufficient numbers of staff available to support people effectively. Robust procedures were in place to ensure that only safe and suitable staff were recruited. However, further routine checks were not systematically carried out once staff were in post.

Staff were not always supported to reflect on their practice or plan their professional development because they did not always receive regular one to one supervision or annual appraisals. The registered manager and the provider carried out detailed audits of the service. However, where shortfalls were identified such as the absence of evacuation drills, DBS updates and staff supervisions action plans were not followed through and the shortfalls persisted.

People were supported with risk assessments and risk management plans to reduce their likelihood of experiencing avoidable harm. Staff were trained to administer people's medicines and did so safely. The environment of the care home was visually clean and staff followed appropriate infection prevention practices.

People had detailed needs assessments and plans were in place to meet those needs. Staff received on-going training to deliver care and support effectively and appropriately referred people to healthcare services when required. People received the support they required to eat and drink well. The service was approaching the end of extensive refurbishments, redecoration and improvements at the time of the

inspection. This had been well received by people, their relatives and staff. People were treated in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Kindness and compassion were in evidence at the service. People and their relatives were pleased with the positive relationships they shared with staff. People's cultures were recognised and they were supported with cultural expression when they chose. Staff promoted people's privacy, dignity and independence.

People received care and support that met their needs and preferences. People participated in activities at home and in the community. Staff supported people to continue to follow their interests and hobbies. The registered manager addressed complaints promptly and in line with the provider's policy. Complaints were reviewed for collective learning and improvement. People were treated with dignity and compassion during their end of life care.

People, relatives and staff spoke favourable about the registered manager. The responsibilities of the registered manager had increased to include the management of another of the provider's services. This meant they were able to spend less time managing people's care at Orford House. The service had an open culture and actively gathered the views of people and their relatives which they were responsive to them. The service worked in partnership with other services and agencies to improve the quality of care people received.

At this inspection we identified breaches in relation to good governance and staff support. You can see what action we told the provider to take at the back of the full version of the 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 were not protected by the readiness of staff to follow an evacuation plan because emergency building evacuation drinks had not been practiced.

Staff were recruited safely with checks made against criminal records and lists of people barred from working with vulnerable adults. However, no further checks against these records were made during the subsequent years in which staff worked at the service.

People's risks were assessed and staff took action to reduce them.

People received their medicines safely and in line with the prescriber's instructions.

Staff followed the appropriate practices to protect people from avoidable infection.

Is the service effective?

Requires Improvement

The service was not always effective. People received their care and support from staff who were not regularly supervised and whose performances were not appraised.

People's needs were assessed.

People's nutritional needs were met and they were supported to access healthcare services whenever they required.

People were treated in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. People and their relatives told us that staff were kind and had developed warm relationships with them.

People were treated with dignity and respect and their privacy

was protected.

Staff encouraged people to express their culture and maintain their independence.

Is the service responsive?

Good

The service was responsive. People received personalised care to meet their assessed needs.

People were supported to engage in a range of activities including their hobbies and interests.

The service responded appropriately to complaints and sought to learn from them.

People received compassionate end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service did not always take action to make improvements when audits identified shortfalls.

The service had a registered manager in post whose responsibilities had expanded to include the management of an additional registered service.

The service gathered the views of people and their relatives and acted on them.

The registered manager worked in collaboration with other organisations to improve outcomes for people.

Orford House 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 checked 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 7 and 10 November 2017 and was unannounced. The inspection was carried out by one inspector and one 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. Their expertise was in care for older people and people living with dementia.

Before the inspection we reviewed information we held about the service. This included reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send to us about significant events that take place within services.

During the inspection we spoke with seven residents, four relatives, two visitors and one healthcare professional. We also spoke with the registered manager, deputy manager, the regional manager, nominated individual and seven staff. We read 12 people's care records and 10 staff files. We read the minutes of team meetings, shift leader meetings and records relating to the management of the service including quality checks.

Requires Improvement

Is the service safe?

Our findings

The registered manager ensured that specialist fire safety checks were undertaken by contractors. These included tests of fire detection systems, firefighting equipment, emergency lighting and the hold-open devices on automatically closing fire doors. However the service had not followed the contractors instructions or the provider's policy which stated that fire evacuation drills should take place. We spoke with managers and staff about the process they would follow in the event of an emergency evacuation. We found there was a general lack of clarity about the actions to take in line with the provider's evacuation plan. Whilst staff said they would support people to leave the building and knew where the assembly point was, they were unaware of the provider's four stage evacuation plan and their roles within it. Staff had received fire safety training and tested call points weekly. But the lack of emergency evacuation drills meant that people were not adequately protected by the preparedness of staff to respond as planned in the event of a fire.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider ensured that people were supported by staff who had been recruited safely. Staff were recruited through a robust process which included the submission of an application, attendance at an interview, the supply of references and proof of identity and eligibility to work in the UK. Staff also submitted to criminal records checks and checks of individuals barred from working with vulnerable adults. However, whilst criminal records checks were undertaken when staff joined the service, no further checks were undertaken once staff were in post. We found five staff with criminal records checks that were five years old. The registered manager explained that DBS updates were at the provider's discretion and would be undertaken if there were suspicions about a member of staff, rather than systematically and periodically for all staff. By not undertaking periodic checks the provider could not know if a member of staff had been convicted of a criminal offence whilst in their employment.

People were protected against abuse and neglect. Staff supporting people were trained to recognise signs of abuse and to take action if they suspected it. Staff we spoke with knew about signs that could indicate someone may have been abused. All staff received annual refresher training in safeguarding adults and safeguarding was discussed in team meetings to ensure that people's safety remained a focus for staff.

People were protected against the risk of avoidable harm because the provider assessed risks to people. Staff undertook generic and specific risk assessments and where risks were identified the provider took action to reduce them. For example, People at risk of falls had their risks assessed. These assessments looked at people's history of falls, along with their medical history, mobility, gait and medicines. To reduce people's risk of falling and increase their safety, people were supported in line with their assessments. Some people were assisted by staff using a supporting arm, others used Zimmer frames under staff supervision. People who walked independently, and who agreed to do so, wore pendent alarms which could be activated to alert staff if they fell.

People who spent significant amounts of time in bed were supported to protect their skin integrity. People's risks of pressure ulcers were assessed. These assessments identified the level of risk by reviewing a number of factors including people's skin type, mobility and continence. Where people were at risk of pressure ulcers staff took action. For example, staff applied moisturising and barrier creams, people used air flow mattresses, pressure relieving cushions and staff supported people to reposition. Where people had arrived into the service with pressure ulcers or had developed them at the service referrals were made to specialist health professionals called tissue viability nurses (TVNs). TVN's oversaw people's wound care and provided guidance to staff to support people's recovery.

People were protected against the risk of malnutrition. People at risk of weight loss had their weight monitored weekly. Where people did not wish to be weighed they had the opportunity for staff to measure and monitor their mid upper arm circumference (MUAC) as part of their nutritional screening. MUAC scores and people's weight measurements provided staff with the information they required to take action to keep people safe. For example, staff made referrals to dieticians when it was identified that a person had lost their appetite and as a result some weight. Staff had guidelines in care records to support people at risk of malnutrition by increasing their calorie intake at each meal.

At the time of the inspection Orford House was undergoing substantial refurbishment work. A new porch and entrance had been build, all flooring was being replaced and the care home was being repainted. We found that risk assessments were in place in relation to the building works. These included trips and hazards, the presence of ladders and power tools as well as minimising people's exposure to dust. Windows throughout the service were fitted with restrictors to prevent people from accidently falling out through them and all external doors were alarmed so that staff were aware if a person opened them. People were able to summon help if they required assistance. People had access to call bells in their bedrooms and there were emergency cords in bathrooms and toilets.

People's medicines were administered to them safely by staff who were trained and assessed as competent to do so. People's photographs were displayed at the front of their medicines records so that staff could confirm that they were giving medicines to the right people. People's medicines records stated what their medicines were for and people's preferences for administration. Protocols were in place for the use of 'when required' medicines. These included how often doses could be repeated and how the decision was reached to administer them. For example, the records of people who were prescribed medicines to manage their anxiety described how their anxieties presented.

People were protected from infection and unhygienic practices. The service had an infection control checklist which was completed each month and staff followed the provider's good hygiene practices when supporting people throughout the day. For example, staff wore single use plastic aprons and gloves when supporting people with their personal care. This ensured that any harmful bacteria would not be transferred between people. The service followed appropriate food storage and food preparation practices. The provider had procedures in place to share information and keep people safe in the event of an illness outbreak at the service. The registered manager undertook audits of infection control practices included staff training, cleanliness around the care home and the correct disposal of personal protective equipment by staff.

Staff were aware of the provider's whistleblowing policy. The provider had a 'concerns helpline' to which staff were invited to raise any issues about people's safety or the delivery of care and support. The telephone number was displayed in the staff room and calls were answered by staff at the providers head office. The registered manager had arrangements in place to review accidents and incidents, whistleblowing concerns and to respond to safeguarding allegations.

Requires Improvement

Is the service effective?

Our findings

People received care and support from staff who were not appropriately supervised. We reviewed 10 staff files and found that seven had not been supervised in a one to one meetings during 2017. None of the staff had been supported to have an appraisal meeting. This meant staff did not have the opportunity to have their performances evaluated or plan their personal development. One member of staff told us, "I haven't had supervision. I would like to so we can really talk things through. Things like the job, the training, the staff." Another member of staff told us, "I think everybody benefits from knowing where they stand. Getting told formally that you are doing well or need to pick up on this or that helps me to help people." The registered manager explained that the service had undergone significant upheavals with a complete change of service leadership, the additional responsibility placed upon the registered manager for the management of a separate service and a high staff turnover at Orford House. The registered manager told us these issues had impacted on their capacity to carry out regular supervision with all staff.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed by senior staff to ensure their care and support was effective. For example, staff undertook assessments of people's mobility and moving and handling needs. These assessments included a determination as to whether people might experience confusion, be uncooperative, experience localised pain or be unable to balance whilst standing. The outcome of people's assessments informed people's care plans which detailed how people's needs should be met.
For example, where people presented with mobility needs and required the use of slide sheets in bed or a hoist to transfer care records stated this and the registered manager ensured that staff were trained and competent to use this equipment.

Staff received an induction when they joined the service. The induction programme included training in mandatory areas, shadowing colleagues as they delivered care to people, familiarisation with the provider's policies and procedures and support to complete the Care Certificate. The care certificate is a nationally recognised training programme which sets the standard for the essential skills required for staff delivering care and support. One member of staff told us, "I was confident once my induction was finished."

People were supported by knowledgeable and skilled staff. The registered manager reviewed and planned staff training using a training matrix. This identified when staff had undertaken or were scheduled to attend training courses. These included moving and handling, first aid, training, mental capacity and health and safety. Staff rotas reflected the information on training matrices. Staff undertook refresher training for all mandatory topics to ensure their skills and knowledge were up to date.

People ate well. People told us they enjoyed the meals offered to them. One person told us, "Oh, it's lovely." Another person said, the food was, "Very nice." People's preference for food and drink were noted in care records. For example, one person's care records stated, "[Person's name] prefers cold milk to tea or coffee." Another person's care records quoted a person as stating, "I do like a nice glass of cranberry juice." People

chose the meals they ate and were offered alternatives if they did not like the options on the menu. We observed one person declining their meal and the alternative available dishes that were offered. The person stated what they wanted to eat and it was prepared for them. People received the supported they were assessed as requiring to eat and drink. Where people required their food to be softened or pureed or their drinks thickened this was stated in care records and followed by staff.

Transfer between services was planned. Staff supported people with pre-admission assessments before they moved into the service. Where people transitioned out of the service, records were made of important information that maybe relevant to the transfer process. This included people's mobility, communication needs, pain and risks. This meant all parties had access to the information they required to support people to transition effectively.

People had access to health and social care professionals as soon as they required. One healthcare professional told us that staff brought people's health needs to their attention in a timely manner. A GP from a supporting practice visited the service regularly. Staff made the doctor aware of people's changing needs as soon as they were identified. For example, records showed staff reported when people were, "off their food", "very lethargic" or had "loose bowels." Staff had information in care records about people's health needs and entered into those records clear accounts of appointments with health and social care professionals and any outcomes from them. This allowed people's health and treatment to be tracked.

The building and environment met people's needs. One relative told us, "This is a lovely relaxing location. There are views of woodlands and a golf course. It is peaceful and relaxing. The service was nearing the end of an extensive redecoration and home improvement programme at the time of our inspection. The service continued to be wheelchair accessible and contrasting colours were used to support people's visual and dementia needs.

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 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).

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. Where people were subject to DoLS we found that records relating to the restriction were in place. This included the assessments undertaken to determine people's lack of capacity along with the best interest decisions and minimum restrictions necessary to keep people safe. Records related to people's DoLS noted the dates on which they were granted and by which they needed to be reviewed.

Good

Is the service caring?

Our findings

People told us that staff were caring and kind. One person told us, "Staff are very nice, very helpful and do everything that they can." Another person told us, "Staff are very pleasant and kind. I can't praise them enough, they're excellent." A third person said, "Staff are very pleasant and kind." Relatives were similarly positive in their comments. One relative told us, "I leave here knowing that my [family member] couldn't be in better hands. I couldn't be happier." Another relative said, "I would say that staff are not just caring they are loving."

People and staff shared positive relationships. Relatives told us that staff knew people well. One relative told us, "The staff know so much about my [family member]. Yes, the care records are good, but what they know about her can only have come from talking with her, spending time with her and building up a trusting relationship. I'm so happy about that." Another relative told us, "Staff have a really good rapport with [family member].The staff go through a scrap book with them and it's wonderful that they can reminisce about their life." The service was developing life stories for people which included information about people's place of birth, details about their parents and siblings, people's childhood memories as well as information about people's working lives. This information was used to aid people's memories and to provide substance to meaningful conversations with staff and other people.

Staff respected people's choices as to the names they wished to be referred by. For example, we met several people who wished to be known by their middle names rather than their first names. We found that staff adhered to people's wishes and this was reflected in care records.

People were supported around individual and collective cultural expression. At the time of the inspection people were preparing for Remembrance Sunday. In advance of the commemoration people were supported to develop art work and written memories of their experiences of the war years. Some people, with the assistance of their relatives, had shared photographs of themselves as children beside their bombed out homes. The service gathered the information and photographs into a book form and placed it on display. People told us they were happy with the exhibition, art work and plans for the event. People who chose to were supported to wear poppies.

The provider ensured that people had access to information about the service. People and their relatives received a service user guide. This included information such as a brief biography and photograph of the registered manager, the provider's philosophy of care, staff structures, activities, fees and how to make a complaint.
People were encouraged to maintain their independence. One person told us, "I do as much as I can. I dress myself and staff help me when I need it." People were given the level of support they required to continue to exercise their independence. For example, one person's care records stated, "[Person's name] is able to walk independently but gets lost or disorientated so needs to be accompanied." Another person's care records noted that they were able to use a Zimmer frame independently but required the support of staff to supervise them as they walked.

Staff respected and protected people's privacy and dignity. We observed staff knocking on people's bedroom doors and waiting for permission to enter. Care records reflected their preferences around their privacy. One person's care records stated, "I like my own privacy and space." Referring to their dignity another person's care records stated that they did, "Not want to fall asleep in the lounge." Staff were aware of this and roused the person if they began to dose and offered them support to go to their bedroom to nap if they chose.

Relatives told us they were made to feel welcome when they visited people. One relative told us, "I can come whenever I like and it's never a problem. The staff are always friendly." Another relative told us, "There are facilities for relatives to just help themselves to a cup of tea or coffee. The staff offer to make them too." People were supported to maintain contact with those who mattered to them. For example, one person was supported by staff to have Skype conversations with relatives using a computer. Staff noted in handover and staff communications records when relatives planned to take people out and ensured people received the support they required to be ready and presented as they wished.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs. One relative told us, "I was involved in [family member's] care planning from the get go. [Staff] have always been good at keeping me informed and discussing what is the best way forward."

Staff delivered care that was personalised and reflected people's preferences. For example, a married couple were supported to share a double bedroom where they received care and support. How people wished to be supported was stated in care records. For example, one person's care plan noted that they wished to have their breakfast in bed. Another person's care plan stated, "I like to be well groomed and well presented at all times."

People had the opportunity to engage in activities. The service had an activities coordinator who led a number of sessions including music, gentle exercise, arts and crafts groups. One relative told us, "There are always activities going on. My [family member] joins in some. By far the most important to her is the glamorous stuff. She loves getting her nails painted and her hair done each week. But just as important to her is for the staff to tell her how great she looks. They never fail to do that." People were supported to play a range of board games. A member of staff told us, "For people suffering from anxiety board games are great for calming them because it changes their focus."

People were supported around their interests and hobbies. For example, one person liked bird watching and was supported to watch birds in the courtyard. In another example, one person who was interested in current affairs was supported to have newspapers delivered to them at the service each day from a local newsagent. People interested in gardening were supported to visit a local gardening centre which contained a café.

People who spent most of their time in their bedrooms had care plans in place and were protected from social isolation. The activity coordinator visited people in their bedrooms to engage in person centred activities. These included hand massages, reading, talking, and nail painting. Some people who stayed in their rooms required the support of staff to listen to their preferred music. We found that care records noted their musical preferences. For example, one person's records stated, "I love listening to music particularly Frank Sinatra and Elvis Presley." Another person's noted "I prefer to listen to my radio than watch the television."

People had the opportunity to attend activities and events such as performances by visiting entertainers both in Orford House and in the provider's other service. The service, which was managed by the registered manager, could be seen through the window of the lounge and was within walking distance. People were supported to attend an event at the neighbouring service during our inspection and told us they enjoyed it.

The provider acknowledged, investigated and responded to complaints. The registered manager and leadership team sought to learn from complaints and take action to prevent the same problem recurring. For example, when a relative complained about aspects of financial information they received, the

information was made easier for all to understand in following communications to relatives from the service.

People were supported compassionately and sensitively during their end of life care. One healthcare professional told us, "A death observed at the service was tasteful with family members present and the person was surrounded by photographs of loved ones. Staff were attentive to the relatives needs too." People identified to be approaching end of life had specific care plans to support them. People's advanced care plans stated the spiritual support they wished to receive. For example, some people who were of Catholic faith had stated in their care records that they would like a priest to be contacted to administer them their last rites if their condition deteriorated. The service work in partnership with the GP, pharmacist and a specialist palliative care team to ensured that people were comfortable and their 'just in case' medicines were available. This enabled people to remain free of pain. The provider maintained contact with relatives for many months after people had died. This aftercare included phone calls, correspondence and invites to events at the service.

Requires Improvement

Is the service well-led?

Our findings

The quality of care people received did not always improve as a result of the quality checks undertaken at the service. We found that where audits identified shortfalls the service had not always taken action. Specifically, detailed audits commissioned by the provider identified that emergency evacuation drills had not been carried out. Similarly audits identified that staff supervision meetings and appraisals had not taken place. We found that whilst action plans had been developed to address these shortfalls the actions themselves had not been undertaken.

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

Management arrangements had changed at the service since our last inspection. Since the last inspection the service has had a new registered manager and deputy and their duties had been expanded. As a result of a restructuring by the provider the registered manager was also registered with the Care Quality Commission to manage a nursing home which was operated by the same provider. This service was within walking distance and both the registered manager and deputy manager spent their time between the two services. Relatives and staff we spoke with were positive about the registered manager and her deputy. One relative told us, "I have to commend the management here. They are the ones responsible for my [family member] having such good care." A member of staff said, "[The registered manager] is very visible, very supportive, very capable." Another member of staff described the management team as, "Good people." Adding, "They care about this service and what goes on." A third member of staff told us, "They lead by example and they have an answer for all your questions."

The registered manager operated an open environment within which staff were encouraged to share their ideas. The registered manager met with her senior staff team each month. Issues discussed during these meetings included shift leading, handovers and resident of the day. Team meetings were also used to discuss people's changing needs and good practice. For example, at one team meeting the registered manager led a discussion about urinary tract infections and the importance of adequate fluid intake. We read discussions which included timekeeping, staff code of conduct, training and housekeeping.

The service's culture of openness included keeping people and their relatives informed and gathering and acting upon their views. The suggestions of people were acknowledged and acted upon by the provider. 21 people responded to the most recent survey of their views by the provider. People fed back that they wished to leave the service more often for trips into the community. The service responded by arranging regular trips for people to a large local garden centre which contained a café, coffee shop and views of wildlife. The provider also invited feedback from relatives and analysed the information it received to reveal trends. For example, the registered manager reviewed relative's responses in a survey and recognised that some relatives did not feel they were updated in a timely way. The service responded by publishing and sending a monthly newsletter to relatives. One relative told us, "I am kept informed." A second relative told us, "They are very good at phone contact if they are unwell or there's a problem."

People received care and support from staff who were happy in their work. Staff we spoke with were enthusiastic about their roles. The registered manager told us they planned to develop the role of infection control champion at the service. This role would involve staff members being training in best infection prevention and control practices, role modelling these to colleagues and observing staff to ensure that good practice is being followed. The registered manager used positive feedback to encourage staff by maintaining a folder of printed complimentary emails and thank you cards which they shared with staff.

Staff did not always feel listened to. The results of the staff survey undertaken in the month prior to our inspection were still being analysed and results were not available. Neither were the results and action plan from the October 2016 staff survey available. This meant that the views and experiences of staff were not always taken into account when evaluating and planning service delivery. Staff told us that this was reflected in the absence of consultation about the extensive refurbishment work that was being undertaken at the service when we inspected. This was acknowledged by the registered manager who explained that a high staff turnover along with management restructuring had hindered the process. However, they highlighted, and staff agreed, that staff views continued to be gathered at team meetings and their suggestions were acted upon. For example, the service introduced a radio system to replace staff use of the call bell system to summon assistance. This meant that call bell activations were only by people who required assistance.

The registered manager understood the legal responsibilities of their registration with CQC and the requirement to keep us informed about important events that took place at the service through the statutory notifications process. Our records showed that the registered manager had consistently done this.

People benefitted from the service's collaborative approach to other organisations. The service worked in partnership with a number of local authorities when placing people, meeting their needs and reviewing their care. Staff worked in alongside healthcare specialist to meet people's health needs following referrals. The registered manager attended quarterly meetings hosted by a beacon hospice service and the local provider's forum where good practice in adult social care was shared and discussed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to protect people against the risk of receiving unsafe care and treatment. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of people. Regulation 17 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate on-going supervision in their role. Staff did not receive regular appraisal of their performance in their role. Regulation 18(2)(a)