Care Homes UK Ltd

Stockingate Residential 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?	Good

Overall summary

The inspection took place on 29 July 2015 and was unannounced. The service provides residential care for up to 25 people, some of whom are living with dementia. At the time of our inspection there were 14 people living at Stockingate Residential Home.

There were several breaches of the legal requirements that we checked at the last inspection in January 2015. Following this previous inspection we took enforcement action because people who used services were not protected against the risks of receiving care or treatment that was inappropriate. We also asked the provider to send us an action plan to show how they were meeting nutritional and hydration needs, maintaining safe premises and equipment and ensuring good governance. The provider sent us an action plan which detailed the improvements they had made and we checked these at this inspection. We found the provider had made significant improvements to the service and to the monitoring of the quality of the provision.

Summary of findings

At the time of our inspection there was a registered manager in post, although not present during our visit. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The service was friendly and welcoming with a calm and relaxed atmosphere. People were supported through caring relationships with staff who understood their individual needs.

People were treated with respect and their dignity and rights were promoted.

Staff had a sound understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff worked together with one another and with visiting professionals to support people's health care needs. Handover information was appropriately shared between staff shifts to ensure people's care was properly maintained.

Staff had sufficient opportunities for regular training and professional development to enhance their skills and knowledge of working with people in the service.

People's care plans were not always robustly followed by staff to enable them to support people's individual needs safely.

Risk assessments were not always updated or followed to ensure people's safety when eating. This was raised at our last inspection as a concern.

People were given good explanations about their medications and staff took time to make sure people were supported to take their medication when they needed to. However, storage of medication to be returned to the pharmacy was not secure.

Systems to monitor and review the quality of the provision were in place.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Individual risk assessments were not always updated following changes or followed by staff as part of people's care delivery.

There had been significant improvements to the premises to enhance the quality of care for people. However, work was still ongoing to ensure people's safety in the garden area and to improve the environment for those people living with dementia.

Staff giving medication were appropriately trained. However, medication to be returned to the pharmacy was not stored safely.

Requires improvement

Is the service effective?
The service was not always effective.

Staff had regular access to relevant training to enhance their role. Staff had regular supervision meetings to support them in caring for people's needs.

People had more choice with meals and the chef understood how to fortify people's diets where they were at risk of weight loss. Weight loss was managed appropriately. However, people's dietary needs and fluid monitoring were not always managed appropriately.

People had appropriate access to healthcare services.

Requires improvement

Is the service caring?
The service was caring.

There were positive caring relationships between people and staff.

People were treated with dignity and respect.

Good

Is the service responsive?
The service was responsive.

People's individual care records were informative for staff to provide personalised care.

People enjoyed the afternoon activities and a new activities co-ordinator had been appointed.

People had access to information about how to raise concerns. They spoke openly with staff and people said they felt they had nothing to complain about.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

The provider had produced an action plan following the previous inspection and had completed identified actions. Systems were in place within the organisation to regularly monitor and review the quality of the service.

The registered manager's office was more accessible and people, staff and visitors had free access to discuss any relevant matters. This helped to create a culture of openness and transparency.

Stockingate Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 July 2015 and was unannounced.

There were three ASC inspectors. We reviewed information including the provider's action plan following the previous inspection. We looked at information from notifications before the inspection. The provider had returned their 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We contacted the local authority commissioners and safeguarding teams before the inspection. We spoke with eight people who used the service and one relative during our visit. We spoke with two relatives by telephone following our visit. We spoke with the supporting managers, and four staff. We observed how people were cared for, inspected the premises and reviewed care records for six people. We also reviewed documentation to show how the service was run.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said they felt safer because there was 'a strong door' on the front of the home. Another person said: "It's safe here, I don't feel I'm not safe in this place". Another person said: "There's always someone there for you, watching out for you".

One relative we spoke with said their family member was 'very safe' at Stockingate Residential Home.

Staff we spoke with were able describe how they would identify different types of abuse and explain what action they would take if they suspected anyone was being abused. Staff we spoke with were aware of a safeguarding policy. Additionally, staff were aware of the whistleblowing policy. One of the staff we spoke with told us they had experience of using the whistle blowing policy. They told us they felt the management handled the whistleblowing incident very well and felt supported through the process.

We asked one member of staff how they would recognize signs of distress with people who had difficulty communicating. They told us: "If I see a person's behaviour has changed, for example if they stopped smiling when they had always been a person who smiled, I would report this to the senior manager." They had a good understanding of the different types of abuse and said they would always report any concerns to the manager and if the management team didn't respond they would contact the Care Quality Commission.

One of the members of staff we spoke with had started employment at the location the day before our visit. Before shadowing their first shift, they had attended safeguarding training and first aid awareness training. However, a longer standing member of staff had not had their safeguarding refresher training since September 2013. We asked support managers to confirm whether this was the case and they confirmed that the refresher training had been missed for this member of staff and they would be booked onto the next training in September 2015. We saw there was accessible information for people, staff and visitors about how to ensure people were safeguarded at all times.

People we spoke with told us they felt staffing levels in the home met their needs. One person said: "I can always find someone and I don't have to wait for what I want".

We saw staffing levels were sufficient to meet people's needs and staff attended to people promptly for assistance with personal care. The staff we spoke with told us they thought the staffing levels were good and did not feel there were any times when the service was short of staff.

We saw that, in one supervision session, it was recorded that a member of staff said "more times than not it is too busy to grab a care plan, so end up having to come in on days off". Staff told us they preferred to spend their time with people during their shift, not doing paperwork. Managers we spoke with told us staff had time to complete records within their shift, but if staff were required to come in they were paid for this.

We saw the provider had made improvements to the premises since our last visit. The ground floor corridor, although slightly sloping, was even, with handrails and signage to alert people to the slope. The carpet showed some early signs of puckering which the supporting managers pointed out to us and said this was being addressed to ensure no trip hazard for people.

We spoke with the person whose room had previously had a leak in the ceiling and which was discussed at our last inspection. They told us they had not had any problems with this since our last inspection and they showed us their room. We saw no evidence of water leakage and the person told us they were very satisfied their ceiling was in good repair. We saw the premises were clean and tidy and free from odours. People freely accessed all areas and chose where to go. People who used the service had access to a garden at the back of the building. We found that, in the outdoor area, there were rubbish bags and old equipment, including a rusty filing cabinet and a dirty mattress. We discussed this with supporting managers who said the outdoor area was to be included in the ongoing programme for improvements. We saw regular maintenance had been carried out; job requests were recorded for the maintenance staff as was action taken.

The supporting managers told us there had been some internal reorganisation to enable medication to be stored at a more suitable temperature than previously found at inspection. We saw the medication room was cool and the fridge was maintained at a suitable temperature for medicines to be stored safely. Room and fridge temperatures were recorded and the senior staff told us these were checked daily to make sure they were within safe limits.

Requires improvement

Is the service safe?

Staff who were trained to administer medication were deployed on all shifts. We saw medication was administered safely and in a person-centred way. The senior care staff took each person their medicine individually and stayed with them to support them if required and to witness they had taken it. We saw this process was not rushed and people were given the time they needed. People told us they received their medicines when they needed them. For example, one person said: "She [member of staff] is always right on time. She knows I don't like the taste but she makes sure I have a drink to wash it down".

Senior staff talked us through the process for managing medicines in the home and we looked at a sample of three people's records. We found these to be in order, correctly recorded and stock balances correct. We saw medication in use was in date and stored securely in the trolley within the medicines room. Controlled drugs were securely stored and all details recorded robustly. The senior staff was aware of the guidelines for homely remedies and PRN (as required) medicines and said if there was any doubt the pharmacy would be consulted for advice. We saw medicines that were to be returned to the pharmacy were not safely stored, however. The senior care assistant explained this was because of limited storage space, but said these were always stored within a locked staff area. We saw this was so, however, noted the staff area was accessible with a master key, shared by all staff. The senior care assistant contacted the pharmacy during our visit and asked for the prompt removal of the returns medication and the supporting managers gave a direction for staff to ensure all returns be stored securely with immediate effect.

Accidents and incidents were recorded in detail and analysed to identify trends and patterns. We saw where action was needed, managers had taken some steps to address areas of concern. For example, we saw one incident record in which a person had been choking on food that was not of a suitable consistency for their needs. As a result of this incident, managers were considering disciplinary action with the members of staff involved and had been carrying out investigations as to how the incident occurred.

However, when we looked at this person's risk assessment for eating and drinking we saw this had not been updated in spite of the incident having happened. Furthermore their care plan stated they should be supervised when eating to minimise the risk of choking. Our observations of this person during the inspection were that they were left unsupervised at mealtimes. Similar concerns had been observed at our previous inspection.

In another of the care plans we looked the dietician had recommended staff use a teaspoon when supporting the person to eat. This was to reduce the risk of choking. We saw staff used a large dessert spoon; this meant staff had not followed the recommendations of the dietician and were not mitigating the risks as suggested for the person's safety.

We observed staff attempted to assist one person to a wheelchair from their lounge chair but the person protested. We saw staff were not following the safe procedure as outlined in the person's moving and handling care plan. We discussed this with the staff and supporting managers, who agreed to make sure this was reviewed immediately.

The examples above illustrated the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(c)(b) as they were not doing all that was reasonably practicable to mitigate risks to the health and safety of service users.

Requires improvement

Is the service effective?

Our findings

People told us: “They do their job alright” and “They know what to do for me”. One relative we spoke with told us staff knew their family member very well and said: “The staff are great with [my family member].” They told us if staff had any concerns, such as with illness or weight loss, they would inform them at once.

We heard supporting managers discussed with maintenance staff ideas on how to improve the environment to make sure it promoted the needs of people living with dementia. We spoke with one supporting manager who told us work was ongoing to improve the environment for people living with dementia. She showed us how staff had tried to make improvements already and there was a life size transfer of a telephone box on the wall with an old telephone for people to touch. However, this was on the lounge wall next to the fireplace and she told us of plans to make sure it was more appropriately positioned as well as plans to address the colour scheme in the home.

We looked at three staff files. We found in each file there was an application form, record of interview, reference checks, and Disclosure and Barring Service (DBS) checks. However, in one of the files, the DBS check was dated July 2007. It is not mandatory for DBS checks to be renewed although for good practice the provider should consider how ongoing suitability of staff is measured and maintained.

We saw there was a supervision agreement in the staff files, stating that staff were entitled to at least six supervisions per year. We saw evidence that staff had received regular supervision, as stated in the agreement. Supervision sessions included discussions of work performance, policies and philosophy of care, abuse reporting, any concerns with staff members, key worker duties, any training needs, timekeeping, sickness and general concerns.

The staff we spoke with told us they had supervision and an annual appraisal. They felt their appraisal was an opportunity for them to identify their training needs. Staff told us they felt the training offered was good. They felt it gave them the skills and knowledge to do their job. They told us the management of the service ensured staff attended the training. They told us: “Management let you know if you don’t do the training.”

We spoke with a newer member of staff who told us they were shadowing more experienced staff. We saw the new member of staff spent time looking at documentation relating to the running of the home. We heard supporting managers had a thorough discussion with the new staff member. They encouraged them to spend time getting to know the people as part of their induction programme before deciding on activities that may be suitable.

Staff had undertaken induction training including fire evacuation, reporting procedures, health and safety procedures, confidentiality, whistleblowing and abuse policy, infection control and dignity and respect, for example. The staffing matrix showed staff training was regularly updated and supporting managers confirmed staff were competent to carry out their work.

However, we found one member of staff’s last infection control training was dated September 2013 and this was valid for one year, but had not been refreshed. We found this member of staff had two certificates of health and safety training provided on the same day but with different expiry dates so it was difficult to determine whether they had received up to date training in health and safety. This could mean that current policies and guidelines were not being followed. The supporting managers agreed the health and safety training had been valid for two years and were satisfied the member of staff’s certificate was still valid.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff confirmed they had received training in the Mental Capacity Act 2005 and in Deprivation of Liberty Safeguards (DoLS). They were able to give us examples of when people may be deprived of their liberty. Staff had an understanding of mental capacity and how decisions may be made in a person’s best interest. Staff were aware that some of the people living at the home were being deprived of their liberty and had a Deprivation of Liberty Safeguard authorisation in place. Staff told us that the front door had a coded key pad so people are unable to leave and the side doors are alarmed so that staff are alerted, should someone try to leave.

Requires improvement

Is the service effective?

In one of the plans we looked at, we saw evidence a Mental Capacity Assessment and a best interest meeting had been held. This was in relation to a specific decision and had been done in the best interests of the person and to keep them safe from harm.

In another care plan we looked at, we saw a capacity assessment had been carried out by another professional. The assessment was thorough and had included the views of the person's family. The professional had also carried out a DoLS assessment and a best interest meeting had been held. This meant the person's rights had been protected because an assessment had been carried out to determine whether they could make a decision in relation to living at the home.

We spoke with the chef. They told us they had a National Vocational Qualification (NVQ) level two in food safety and had training in diabetic diets, healthy eating and nutrition. They had a good understanding of what constituted a healthy meal and how to fortify foods. They told us: "We put butter into the mashed potatoes and we use full fat milk and cream in puddings, milkshakes and in people's drinks".

The chef told us they sat down and spoke with people new to the service and asked them about food and drink preferences. If people were unable to communicate, the chef said they would talk to the families to find out people's likes and dislikes. However, the chef acknowledged people's tastes change and they said they kept up to date with people's preferences through feedback from the care staff.

Staff told us people had choices in their meals and the chef would make them alternatives if they wanted. We saw when one person chose to get up later than breakfast time, they were offered a choice of different foods. The supporting managers told us menus were available on the dining tables and on the board outside the kitchen so people could see what was available. One person took us to the menu board and pointed to the choices, although they could not remember whether they had been asked.

We observed a mealtime experience in the lounge area. One person was given a plate containing a sandwich and some potato croquettes. The person was given a (large) spoon to eat this with, which did not appear to be appropriate. The person took a bite of their sandwich and said "my dinner's not very nice". A member of staff asked if the person would like corned beef hash instead and the person agreed. The member of staff took the person's sandwich away. Five minutes later staff gave the person a bowl of corned beef hash. The person struggled to eat this, repeatedly saying "there's nowt on it", looking at their spoon. No staff had assisted the person to eat their corned beef hash. Ten minutes later a member of staff came and asked if the person wanted some 'mash' instead. They took the corned beef hash away and came back at five minutes later and said: "[name], we're just going to bring you some bread and jam. You like bread and jam don't you". The bread and jam was brought shortly afterwards. The person then became agitated and began to raise their voice and the staff member walked away saying "okay, there's your sandwich" and left the person alone to eat the jam sandwich. A different staff member then approached and offered the person assistance to eat their sandwich. The person said "I don't want it".

Although this example shows the person was offered a range of different food, we saw their care plan stated they should be supervised at all times when eating to minimise the risk of choking. We saw this did not happen and there were several periods of five minutes or more in which there were no staff present when the person was eating.

There was mixed practise with regard to staff support for people at mealtimes. For example, we observed some people received effective support to eat their meals. We saw staff sat down by the side of people and food was offered slowly so people had the time to swallow their food. Staff were patient and followed people's non-verbal cues, such as facial expressions where people were unable to speak with staff to express their needs.

However, another person in the lounge seemed confused as to how to eat their lunchtime meal. We saw they collected food in their hand and didn't know what to do with it and there was little staff support for some people to assist them with eating their food successfully.

Some people who used the service had memory problems and had difficulty choosing food from the menu. This was because they had difficulty recalling what certain types of dishes looked like; for example, people may not be able to recall what shepherd's pie looked like and would not be able to choose it from the menu. For example, we saw staff offering people a choice of dessert but one person said 'I

Requires improvement

Is the service effective?

don't know what those puddings are'. Staff did not show the person the different types of dessert. They ended up with a dessert recommended by the staff member and this took away the person's ability to choose.

The service used photographs of different types of food so people with memory problems could choose food from the menu. However, the pictures were often faded and it was difficult to establish the different types of food on the photographs.

We looked at the minutes from the residents' meeting and food/menu choice was not on the agenda. The chef could not tell us whether people who used the service were asked their opinion of the food, such as the quality and whether there was enough choice.

We saw there were snacks available throughout the day and included crisps, fruit, cake and biscuits. Staff we spoke with told us they knew people's favourites and tried to offer people things they enjoyed. For example, staff said one person 'would drink tea all day long' and we saw this person was frequently offered drinks of tea.

We looked at the weight records for six people and saw their weight varied from month to month and where people had lost weight, the service referred them to the GP and their weights had been recorded weekly.

Where people's fluid intake was being recorded, we saw this wasn't being done on a daily basis or in a consistent way and there were gaps in recording. For example, in one care plan the fluid charts had been filled in on the 27th of July and the 29th of July but not the 28th of July, On the 27th of July, the person had been recorded as having a fluid intake of 700 millilitres. This may not have been adequate to protect the person from the risks of dehydration.

In two care plans we looked at, we saw choking risk assessments were in place. Where risks had been identified the service had made a referral to the Swallowing and Language Therapy service (SALT).

The staff we spoke with told us they felt the service responded quickly to changes in people's heath and well being. In the care plans we looked at we saw the service referred people appropriately to other health professionals when any changes in health had been observed or when emergency arose. For example, in one of the care plans, we saw the person had a fall and although they were assessed after the fall, the next day staff noticed the person was in pain and the service contacted the ambulance service and the person was taken to hospital.

We observed staff worked closely with a visiting district nurse and communicated with them to ensure people's care needs were met. We saw district nurse notes were clear and accessible to staff for continuity of people's care.

We saw in one staff area there was a clear schedule of which person had forthcoming hospital appointments and these were also recorded in the staff communications book and handover notes. Daily handover reports were detailed for staff taking over from each shift.

Good

Is the service caring?

Our findings

We observed staff to be very kind and caring in their approach and we saw incidents of spontaneous affection, such as hugs and hand-holding between staff and people in the home. We saw staff treated people with respect and spoke with them in a courteous way. We heard staff using the names of people repeatedly when speaking with them. When care and support was offered, such as when medication was being given, we heard the staff member carefully explain what is was and what is was for. Staff knelt down so they were at the same level as the person when speaking with people.

Staff noticed a person had cold arms and they asked them if they were feeling cold and offered to get them a cardigan. Staff brought a cardigan for the person and checked they wanted to wear it before assisting them.

We observed staff discreetly ask a person if they wanted assisting to the toilet. The person agreed but then changed their mind once they began to move. The staff acted appropriately and tried other approaches whilst remaining discreet. Once the person eventually agreed and began to walk to the toilet, the staff member was repeating "you're doing really well". The person said "Am I?" and the staff member said "Yes, you are". It was very caring in nature.

Staff told us they had received training in dignity and respect and they always tried to treat people with respect. Staff knew the people who they supported well. They used their knowledge of people's history and background to engage appropriately with people.

The staff we spoke with told us they felt people were treated with dignity and respect. They told us "People here are treated well." Staff told us they enjoyed working at the service. One staff member told us: "I love working here, I really enjoy it and I love the residents."

We saw people's end of life wishes were not always recorded as having been discussed. Not all of the care records we looked at had an end of life plan in place so it was difficult to establish what each person's wishes were. In one of the plans we saw evidence the service had involved the family in the end of life plan. There was a business card for a funeral director but no other information regarding what the person wanted at the end of their life. Another plan we looked at had a clear end of life plan of care.

Good

Is the service responsive?

Our findings

People told us they had enough to do and they spoke about activities that took place at times in the home. One person we spoke with showed us a wall transfer on the wall depicting an open window and said: "I like that. It's like somewhere I know, but I don't know where". We saw there was a television programme on, but only one person was watching it. One person said: "I'm happy sat here, I'm comfy and content".

On the morning of our visit, we heard one person say "I'm fed up". A carer responded by saying "We'll see if we can walk to the shop later". Later in the morning, a member of staff did accompany a person to the shop. Staff told us they knew the person enjoyed going out and in times gone by had used to ride a bicycle to many places. Staff said the person believed their wheelchair reminded them of wheeling along on their bicycle.

There were pictorial signs on toilet and bathroom doors enabling people with memory problems to remain as independent as possible.

We observed one person being assisted to walk to the toilet. The care plan for the person stated that the person would require 'verbal prompts and reassurance'. We saw this in practice. The plan stated that staff should walk in front of the person, and we also observed this in practice.

On the morning of our inspection, we noted that there was little interaction and activities for people. We were told activities were planned and carried out in the afternoon, the activities included; pin bowling, board games, word games, chair exercises and external entertainers. We saw people took part in the activities and appeared to enjoy them. For example, in the afternoon, we saw people dancing with staff to music and a soft football being kicked and 'headed' in the lounge. A number of people were enjoying this, although we saw some people were still seated alone and were not included in meaningful activity.

An activities co-ordinator had just been recruited into the service. We saw people who used the service chatted with each other and kept each other company in the lounge.

Where one person chose to stay in their room we saw they listened to music and staff made regular checks to see if the person wanted anything.

We looked at the care plans for six people who used the service. In one of the plans we looked at we saw a background history of the person. The history gave staff an insight into what the person was like and what they did for a living before they moved into the home. Another plan did not have a background picture; the service had requested information from the family in May but this had not been chased up. This meant it was difficult for new staff to get to know the person and have a picture of their background.

People had signed consent to having their photograph taken, to have their medicines given to them by staff and they had read and agreed to their care plan. Where the person was not able to sign their consent, a designated person or family member had done so. In the care plans we looked at there was evidence to show people had been involved in the development of their care plan and reviews.

The care plans we looked at had been reviewed monthly and there was evidence the plans had mostly been updated to reflect any changes. The plans covered areas such as mobility, mental state, social interests and personal safety.

We saw the complaints procedure was displayed for people and visitors to see. One person told us: "I've nowt to moan about but I wouldn't be backwards in coming forwards if I did". Supporting managers told us there had been no complaints received since the last inspection.

Good

Is the service well-led?

Our findings

Relatives we spoke with said they thought the home was well run and the registered manager was approachable. One relative we spoke with said they felt they worked in partnership with care staff to make sure their family member's care was appropriate for their needs.

One relative said they were aware of the home having had previous poor inspection outcomes, but they felt things were 'getting better'. They told us: "They're improving, for sure".

The staff we spoke with told us they felt the registered manager was approachable and supportive. They felt the service had improved with the registered manager in place. Staff told us the registered manager made checks of their practise and they regarded this as positive, to ensure people were receiving good enough care. Staff reported an improved culture within the home and felt people received a good standard of care.

The staff we spoke with said they felt supported in their roles and they felt they were given the opportunity to develop. One of the staff members had recently changed their shift working patterns, taking into account their personal circumstances, and this helped them to feel valued as a member of the team.

Staff we spoke with told us they attended staff meetings. We looked at the minutes of staff meetings and saw staff meetings at all grades had been carried out. The agenda was varied and there was a good representation of staff at the meetings.

We saw the registered manager was supported by senior managers within the organisation. For example, on the day of our inspection there were supporting managers in the registered manager's absence.

We saw the newsletter for July 2015 was available to people and visitors and was informative with topics such as redecoration of the home, people's birthdays, staff qualifications and promotions.

We saw evidence of regular, robust audits carried out to ensure the quality of the provision. For example, kitchen audits, medication and health and safety audits resulted in action plans to address identified areas of weakness. Documentation in support of the running of the home was well organised and easily accessible to staff. Quality surveys sent to people, relatives, visitors and staff were carried out in June 2015 and we saw positive feedback was received. Overall, respondents were 'very satisfied' or 'satisfied' and the provider produced a 'you said, we did' summary for people.

We saw the provider had worked through their action plan following the previous inspection and produced results within a realistic timescale. The provider had been open and transparent in showing the ratings from the previous inspection and we saw these were displayed in the entrance for people and visitors to see.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks to the health and safety of service users. How the regulation was not being met: People who used services and others were not protected against the risks associated with unsafe storage of medicines because medicines for returning to the pharmacy were not secured safely. Risks assessments for individuals had not all been updated and staff did not always follow people's risk assessments to maintain their safety.