Lifestyle Care Management Ltd

Heritage Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 and 26 July 2016. The first day of the inspection was unannounced. We told the provider we would be returning for the second day. This was the first inspection since the provider registered with the Care Quality Commission, the service was previously registered under a different provider.

Heritage Care Centre is a care home for people requiring nursing or personal care. It is split over three floors and has four separate units for people. All bedrooms are single occupancy with ensuite facilities. At the time of the inspection, there were 68 people using the service across the four units. The units on the ground floor were for people that required nursing care. The units on the first floor were for people living with dementia and who required nursing care.

There was a registered manager at the service. 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 using the service and their relatives told us that staff were caring and friendly. People said they felt safe in the presence of care workers and we found that care workers were familiar with people's needs and preferences in relation to their personal care and meals. They knew about their underlying health conditions and how they would support them with this aspect of their needs. Many of the care workers we spoke with had been working at the service for a long time which meant they were able to develop caring relationships with people. We saw many examples of caring interactions between staff and people using the service during our inspection, for example during medicine rounds and at mealtimes.

People were supported to take their medicines appropriately. We observed a nurse on a medicines round during the inspection. They asked for people's consent and explained what their medicines were for before administering them. The ordering, storing and disposal of medicines were safe.

People told us they enjoyed the food at the home. People had their dietary and cultural preferences met. People on special diets were also supported appropriately. There was a four week rolling menu at the home, with the main meal served at lunch.

We found that there were sufficient staff to keep people safe and to support them. A nurse was assigned to each unit, supported by a number of care workers. Extra staff were called upon if people needed one to one support. The provider had thorough recruitment checks in place which helped to ensure appropriate staff were employed.

Staff received regular supervision from their line managers and said they felt supported. However we found that the training they received was not always being completed in a timely manner. The training matrix

indicated that staff were not meeting the provider's expectations with regards to ongoing training.

There were risk assessment and risk management plans in place which helped to ensure that people were protected from harm. People were assessed against the risk from falls, challenging behaviour, pressure ulcers, malnutrition, infection and dehydration. For each assessed risk there was an associated care plan and care plan evaluation in place which helped to ensure the risk was being managed properly.

The care records were in the process of being transferred across to a new format and the registered manager told us they had not completed this process. Although the new care plans were easy to follow and well laid out, we found that information was missing from the ones that had been completed and in some cases staff were not completing records correctly.

Although staff showed a good understanding of the Mental Capacity Act 2005 (MCA), consent and how to act in the person's best interests, we found records in relation to these were not always fully complete and did not evidence people's consent appropriately.

Staff praised the registered manager for her approach and said she listened and they felt supported. There were some vacancies in the management team of the home which the provider was looking to fill; this included a clinical lead and a deputy manager to support the registered manager in her role.

A number of audits took place which meant the provider had a good oversight into any issues that needed attention.

We found two breaches of regulation in relation to staffing and consent. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People using the service told us they felt safe in the presence of care workers.

Individual risk assessments were in place. For each assessed risk there was an associated care plan and care plan evaluation in place which helped to ensure the risk was being managed properly.

Robust recruitment checks were in place.

Staff were competent when supporting people with their medicines. The ordering, storing and disposal of medicines were safe.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

We found that the provider was not ensuring that staff were up to date with their required training. This was picked up in the providers own training audit.

Although consent was sought when supporting people with personal care, their meals or their medicines, we found that consent forms and mental capacity assessments were not always completed.

People's health and dietary support needs were met by the provider.

Is the service caring?

Good

The service was caring.

We observed many examples which demonstrated that care workers had a caring attitude.

People told us that the staff were friendly and respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

Information contained in care records were in the process of being transferred into a new style of documentation. We found examples of missing information and some records that were not completed correctly.

People told us they knew who to speak with if they wanted to complain and everyone was given a service user guide containing details of how to complain.

Is the service well-led?

Good

The service was well-led.

There was an open culture at the service and staff told us the registered manager was approachable.

Quality assurance checks were in place and these were effective in picking up some of the concerns we found.

Heritage Care Centre

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 21 and 26 July 2016 and was unannounced. This inspection was undertaken by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this. On this inspection the specialist advisor was a qualified nurse.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make.

We spoke with eight people using the service, three relatives and 12 staff members including the registered manager, chef, activities co-ordinator, nurses, care workers and domestic staff. We looked at records including care records, training records, staff records, and audits.

During the inspection, we spoke with two visiting professionals. After the inspection, we contacted eight health and social care professionals to gather their views and received responses from four of them.

Good

Is the service safe?

Our findings

We found that there were sufficient staff to keep people safe and to support them in their health and welfare needs. A nurse was assigned to each unit, on the day of the inspection there were three permanent nurses and one agency nurse on shift. They were supported by three or four care workers depending on people's needs. During the inspection we saw staff responding to call bells in a timely manner.

One staff member told us that they had enough staff and were always able to call for assistance from the other units if they ever needed it. Another staff member told us, "There is always one staff in the main area to observe people and also to respond to any calls from the residents. We work well together here." The shift co-ordinator told us that, "The number of staff reflect the needs of people, the activities for the day and appointments. We plan things in advance and can request for extra staff if it is required. When there are emergencies, for example, if we have to take somebody to hospital in emergency, then we can redeploy from other units." We saw this in practice in one unit where an extra member of staff had been brought in to provide one to one support for one person using the service.

The regional director told us they planned to implement a formal dependency tool to allocate the required number of staff in future. We were shown this during the inspection and sent a copy of it afterwards.

The provider had thorough recruitment checks in place which helped to ensure appropriate staff were employed.

Staff files contained a pre-employment checks confirmation form in which the provider verified that the references had been received and the correct paperwork such as identity checks, proof of address and right to work in the UK evidence had been seen. Proof of qualifications was sought and Disclosure Barring Service (DBS) checks were in place. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Staff files contained an application form, their curriculum vitae (CV) and job interview details in which staff were scored in areas such as experience, personality, appearance, education and capability. This meant that staff were recruited on the basis of their suitability for the role.

There were risk assessments and risk management plans in place which helped to ensure that people were protected from harm.

Amongst the areas covered were risk from falls, behaviour that challenged, pressure ulcers, malnutrition, infection and dehydration. For each assessed risk there was an associated care plan and care plan evaluation in place which helped to ensure the risk was being managed properly. For example, a nutrition and hydration assessment was carried out on admission. This identified people at risk of harm due to their diet and action to be taken to manage the risk. We saw evidence that where people had been assessed as being at high risk that the appropriate action was taken. A person had scored high on the Waterlow scale and records stated that the GP was to be contacted and a referral to be made to the tissue viability nurse.

(The Waterlow scale is a pressure ulcer risk assessment and prevention tool). The provider had followed this guidance and we also saw a seating assessment review from an occupational therapist to find a suitable chair for this person, which had been purchased.

Risk assessments and safety checks were also carried out on the environment. A fire risk assessment from February 2016 identified a moderate risk and required action by the provider to reduce the risk. The registered manager showed us a report of actions for this fire risk assessment demonstrating they had taken the concerns on board and had started to take action against some of the identified concerns.

Current certificates were seen for the following areas; portable appliance testing, fire detection and alarm systems, fire extinguisher certificate of inspection and a gas safety certificate.

Medicines were managed appropriately. A nurse was allocated to administer medicines on each unit. We observed a nurse on a medicines round during the inspection. Staff confirmed they had training in medicines management and their competence was checked.

The staff observed the 'six rights' of medicine administration, the right medicine, the right route, the right time, the right client, the right dosage and the right documentation. We observed the nurse taking time to check each medicine on the medicines administration record (MAR) sheets before handing it over to people, explaining what each medicine was for and giving people choice in the order they wanted to take them. There was a PRN protocol in place for the use of as required medicines. (PRN is term commonly used to describe medicines given when necessary).

The provider had one supplying pharmacist and had developed a good relationship with them. When medicines were received by the home they were checked and logged. The provider's records detailed the date received, name of the person they were for, the name of the medicines and the quantity. Used medicines were disposed of appropriately by staff and collected by a specialist contractor. Medicine audits were carried out regularly by the pharmacist, with action plans developed for any areas to be addressed.

The ordering, storing and disposal of medicines were safe. Medicines were locked in locked trolleys and cabinets and within the recommended temperature to keep them safe when not in use. Medicines that were required to be stored in cold temperatures were kept in the fridge. The records showed that the temperature of the fridge was checked and recorded daily. The nurse knew the action to take if the temperature of the fridge was too low or high, telling us, "I would transfer the medicines to the nearby unit and contact the pharmacist and GP."

Records showed that controlled drugs were administered and witnessed and signed by two qualified nursing staff. Used controlled drugs were destroyed and recorded by two qualified nursing staff using the denaturing kit. All the medicines in the controlled drugs cabinet were accounted for in the register. The medicines keys were kept by the registered nurse.

People using the service and relatives that we spoke with told us the service was safe. Comments included, "[My family member] told me [they] felt safe", "Yes there are always people about", "Yes because I had a bad fall and if anything were to happen they are here to look after me" and "Yes, it's my place."

Staff told us they have had training in safeguarding. They knew the different types of abuse and had a good understanding about their responsibilities to protect people from abuse. One staff member told us, "If I see that somebody has a black eye I will report it straight away to the manager and she will contact the safeguarding agency and the police if necessary. It is important to take a picture after getting the resident's

consent."

Requires Improvement

Is the service effective?

Our findings

We asked people using the service if they thought the staff were well trained to support them. They told us, "Yes they are helpful", "They are wonderful" and "Yes they are very good."

Staff told us they had an induction when they first started work and said they received regular supervision. Training covered subjects such as fire safety, moving and positioning, food hygiene, infection control, first aid, wound management, health and safety, the Mental Capacity Act 2005 (MCA), equality and diversity, the use of hoists and rails, and risk assessments.

The care workers told us that the qualified staff and other professionals, such as the occupational therapists, dietitians, physiotherapists, district nurses, specialist diabetic nurses and pharmacists also supported them to do their job effectively by providing training and guidelines. One care worker told us, "After I had done the training using the hoists I was shadowed by the more experienced staff until I felt confident to use it on my own." Another care worker told us, "The nurses are very good and you can always ask them if you are not sure and require help."

Despite these positive comments, we found that the provider was not ensuring that all staff were up to date with their required training. We asked for an up to date list of all the training that had been delivered to staff. This showed that the highest compliance level against training was at 81%, this was for diet and nutrition. Only 60% had completed training in safeguarding adults, moving and positioning and managing behaviour that challenges. 73% had completed dementia awareness training and only 46% had completed the safe administration of medicines foundation course. The registered manager told us they had recently introduced a new training programme and system for staff training and monitoring and were still in the process of familiarising themselves with it. We could not be assured that all staff were up to date with their training and that they therefore had the necessary skills and knowledge to meet people's needs effectively.

An internal audit of training for the staff at Heritage Care Centre that we saw during the inspection identified that only 47% of training had been completed.

The above identified issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS).

A section of the care plan was entitled 'mental state and cognition' which in some cases included a mental

capacity assessment carried out on the day of admission. We saw evidence that this assessment was done in consultation with family members and a nurse and included the two stage test for assessing capacity. However these documents were not always in place in the records we saw and in some cases were not signed. In the 'mental state and cognition' record for one person there was no mental capacity assessment. The records for this person indicated that this person had capacity but they had not signed the forms. Consent forms in other records were also not fully complete. There were bed rails risk assessments and bed rail checks in place. However, the records showed that people were not always involved and there were no consent forms. When we asked staff about these records, they said they were transferring records to new notes, and could not produce completed consent forms.

The above identified issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had training in the Mental Capacity Act 2005. They showed good understanding of consent, assessment of capacity and how to act in the person's best interests. One staff member told us "When a person lacks capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive." Another staff member said "The way I use the MCA in my daily work is my daily practice, giving them the opportunity to choose about simple things like, what time they would like to get up, what type of clothes they would like to wear, whether they would like me to cut their food for them."

We saw a number of instances during the visit where the staff asked for people's consent, for example during the medicine round asking people "Which tablet would you like to take first?" and at meal times asking people about the choice of food and drink and also whether they would like any help.

One staff member told us that, "Sometimes people's capacity can change and they may lack capacity. If we have to restrict their freedom for their safety, they would require a MCA assessment and their freedom can only be restricted if it is in their best interests. And where their liberty is restricted we have to apply for DoLS." There was evidence of best interests meetings that had taken place where people did not have the capacity to understand certain decisions that needed to be taken.

The chef told us there was a four week rolling menu at the home, with the main meal served at lunch. Food was prepared and cooked in a large kitchen and then brought down to individual kitchenettes on each unit to be serviced. Food was left in the kitchenettes if people wanted snacks in the evening or night.

Good infection control practices were adhered to. There were separate sinks for hand washing, meat and fruit and vegetables. Colour coded food preparation boards were used. These steps helped to prevent cross contamination. A cleaning schedule was in place to ensure the kitchen environment was clean. There was a chilled room, a dry store and fridge/freezer temperatures were taken daily which helped to ensure food was stored and prepared at the correct temperature.

We spoke to the chef who told us they were given appropriate information from staff about people's dietary and cultural preferences. A noticeboard which had details of special requirements/preferences was on display in the kitchen. The chef told us notifications of individual diets were sent up to the kitchen when people first moved into the service, giving information about their religious, cultural and medical related food needs.

One person told us "The food here is very nice, you should have some." Another said, "It is five stars."

During breakfast we observed that there was plenty to eat. The following items were available to people,

cooked breakfast, porridge, scrambled eggs, cereal, tea/coffee and toast. People were sat around the table and those in wheelchairs were transferred to the chairs at the dining table. The menu displayed on the tables had coloured pictures of the food and the food served matched the food on the menu. There was a choice of food and drinks. People were served by staff wearing protective aprons. The food was kept warm in the heated trolley. People who preferred to have their food in their rooms were served by staff and given assistance. There was a relaxed atmosphere. One staff member told me that "The way we respect people's faith here is to ensure that they have food according to their religion, some of them have vegetarian, and no pork."

We saw a number of examples which demonstrated the effective input from staff and health professionals for people requiring nursing care. For example, when we asked the staff to describe the care of a person's pressure ulcer and the treatment given, they displayed effective knowledge and skills in different areas and also understood the involvement of other professionals when required. When we followed this up with the person, they told us "[staff member] is very nice and I am getting better".

In another case there was a care plan in place for a person who had a poor appetite and was refusing to eat. The nurse had contacted the person's family member and constructed a list of the person's food habits and favourite foods and with the help of other professionals had designed guidelines for the team. The intake of food showed improvement following the above intervention.

Most of the care records showed input from other professionals. We saw referrals had been made to professionals such as dietitians, tissue viability nurses and the community behavioural team. Visiting professionals that we spoke with told us, the provider was good in terms of making referrals and contacting them for advice. They also said the nursing staff knew the people at the home, were knowledgeable about health issues that needed specialist input and kept them up to date with any changes.

Care records for people with diabetes were in place. These included evidence of involvement of the diabetic nurse, dietitian, GP and optician and regular daily blood sugar monitoring. Information on diabetes was also available for staff.

People who had wounds were supported appropriately. They had wound care records which included an assessment, use of body maps to locate the wound, use of photographs to indicate progress, use of air-mattresses, incontinence pads, regular washing, application of barrier creams, involvement of district nurses, a Tissue Viability Nurse (TVN) and the person's GP.

Good

Is the service caring?

Our findings

The feedback from the people we spoke with was positive. Some of the comments from them when describing the care workers included, "Kind, very good, very nice, caring and hardworking." They said the staff were kind and they were treated with respect, "Yes they are polite" and "Yes they are very nice."

We observed a very relaxed and calm atmosphere in the home and positive interaction between staff and people using the service. Staff approached people in a very respectful manner and did not rush them. We saw some good examples which demonstrated a caring attitude, for example, during medicine rounds, a person was very worried about their call bell. The nurse took time to listen to the person, then checked the call bell and ensured that they were happy with the response before proceeding to the next person. The nurse told us, "I could not leave [person] worrying about the call bell, I believe it is the caring thing to do." With another person, the nurse gave her mouth wash before and after medicine and explained that the person always used to complain of a bitter taste and "By giving [person] a mouthwash before I make sure that their mouth feels fresh and after to remove any bitter taste."

Staff supporting people to eat were attentive, engaging through conversation and kind, however those at tables who were eating independently were sometimes left by themselves and no engagement was exercised. When staff did engage with people, they were kind, their body language was open and they spoke with respect and dignity. Staff knew people's likes and dislikes for example, knowing the correct temperature for the drink. One person spilt their drink and staff were very sympathetic, kind and patient.

Staff that we spoke with knew the people using the service, their likes, dislikes and preferences and were able to talk about their care without access to their notes. One of the staff told us "When you have been here as long as I have been you get to know people very well."

A dignity board was on display, giving information about dignity in care, identifying dignity champions within the service and there were notices on display, for example there were articles around to remind staff about the importance of dignity in care. On the week of our inspection, the focus was on dignity in care in eating and drinking. Staff were reminded of ways in which they could promote dignity, for example by calling people by their preferred names. There was also a relatives and Gold Standard Framework (GSF) board on display, providing information about dementia, the Care Act and GSF. (The Gold Standards Framework is a widely used training programme for care homes to support older people with end of life care needs).

Staff told us that the ways they respected people's dignity was by giving them choice, knocking on their doors before going in, by giving them the choice of being cared for by male/ female staff and explaining things to them.

When we asked people if staff respected their privacy and dignity, they told us "Yes they are good and I feel comfortable" and "They are courteous."

Some people had personal mementoes on the doors of their rooms and their rooms were personalised with family photographs, and items in respect to their religion like crosses and bibles. The activity board also indicated that priests visited on a weekly basis. One staff member told me that "I am not religious, but when the resident asks me to read to them, I duly oblige."

A section called 'residents details' included information about people's admission, their past medical history, their medicines and baseline observations on admission. It also included details of their life history which included information about people's background, family and working life, what they enjoyed and dietary likes. These were completed by family members in the records that we saw.

Requires Improvement

Is the service responsive?

Our findings

People using the service had care plans in place and we found there was a clear process for the assessment, planning, implementing and evaluation of care. Care was delivered by a system of key working. The nursing staff were the co-ordinators of care and assessed, wrote and evaluated care plans and the key workers were responsible for the implementation of care.

The registered manager told us that they were introducing new care plans to the service and staff said they had been migrating information from the old notes to the new ones. Care records were divided up into 16 different sections and were well laid out and easy to follow.

The care records we saw were at different stages of completion. At the time of our inspection we found that not all of the information had been transferred from the old to the new style care plans.

There were monitoring tools such as risks assessments, Malnutrition Universal Screening Tool (MUST), fluid balance charts, Waterlow, repositioning charts, bed rail checks and air-mattress charts in place. However, there were some gaps and errors in the records we saw. For example the repositioning chart for one person was difficult to locate by staff. When they did locate it, we found gaps in the records and no guidance on how often the person needed to be repositioned. The Waterlow assessment for one person was scored as 27 which is a high risk but in the care plan it stated that the person was at low risk of developing pressure ulcers.. There were fluid balance charts for a number of people. The fluid balance charts did not always record people's weight or daily target for fluid intake.

We also found other information was out of date. For example, information on display in the nurse's office was out of date and some people that were no longer at the service were listed on the allergies list and some key worker details were out of date. Old records were present in people's rooms, one room had call bell checks in place from 2011 and these for a previous resident. We saw a hospital passport for person that was not dated and the section for medicines not fully complete. Other old records included a 24 hour daily report, the last one seen was from 03/02/2016 and the nurse was not familiar with it. She said they completed a daily handover which was used instead. We found that this also had some gaps and did not always record who the nurse on duty was and some dates were missing. We recommend the provider removes old records to avoid the risk of old notes causing confusion for staff who need to refer to the most current records to provide appropriate care.

There was a dedicated activities co-ordinator at the home, they provided a timetable of weekly activities which were displayed in a pictorial and colourful style, with large print format in the home. They also provided a daily newsletter (The Daily Sparkle), which presented historic news of the day. We found that activities advertised for the day of the inspection took place and were well attended. A newsletter gave information about recent activities that had been held including a ballet performance by the London children's ballet, the heritage summer fete where arts and crafts made by people using the service were sold and a reminiscence art project.

People told us, "We've had two parties this week, this afternoon there's bingo, questions in the Daily Sparkle" and "We do keep fit and a singing group."

People told us they would feel comfortable raising concerns, if they had any. They said, "I can speak to staff and they sort it out", "I've never needed to (make a complaint)", "I go straight to the manager" and "I would tell a member of staff"

There had been no formal complaints received in the past year. There was a complaints policy in place and details of how to make a complaint were kept in people's rooms. People were also issued with a service user guide containing details on how to make a complaint and what steps they could take if they were not satisfied with the outcome.

Good

Is the service well-led?

Our findings

Staff that we spoke with praised the registered manager for the help and support she provided to them. They told us she was approachable and made herself available to speak with them. A number of staff we spoke with had been at the home for at least 10 years. They described their manager as very understanding and supportive and said they ensured they were supported and equipped to meet the needs of people using the service. They told me that they could discuss anything with the registered manager.

We found the registered manager to be open and honest. She was heavily involved in the running of the service and acknowledged the shortfalls that we found during the inspection. She told us that recent changes with the provider meant that the care records and training needed overhauling which had left them playing catch up. She told us that they were looking to recruit a clinical lead and she had requested a deputy manager to take on some of the leadership tasks. There were two nurse vacancies at the time of our inspection which were in the process of being filled. Despite these difficulties the registered manager identified areas that she wanted to improve in future including creating a communal space for people on the ground floor.

The aims and objectives of the service highlighted how people could expect to be treated, these included privacy, dignity, choice, rights and fulfilment. In our conversations and observations of staff, we saw that these principles were being adhered to. The home had achieved accreditation in the Gold Standards Framework (GSF) in end of life care

Relatives and residents meetings were held. Residents' meetings were facilitated by the activities co-ordinator and people were given the opportunity to discuss issues that were important to them. A one to one survey with people about the menu was carried out and we saw that action had been taken in response to the feedback received.

During the inspection the registered manager and staff told us they were in the midst of changing a lot of their records due to a change in the management of the service. This included the training of staff, their supervisions, care records and other documentation related to the management of the service such as audits. We found that this had an impact on the quality of the service provided to people. The case records were at different stages of completion and there were gaps and missing information in the records we saw, training was not up to date and some staff were not clear on the correct documentation that needed to be completed.

A number of tools were used to monitor the quality of service. A quality assurance survey was carried out every three months against the five key areas of the Care Quality Commission (CQC) methodology. We reviewed the most recent one from May 2016 and found that these were effective in picking up the issues we identified during the inspection. For example, training, Deprivation of Liberty Safeguards (DoLS) and care records. Individual care plan audits also took place and although this tool identified a number of problems and had action plans in place, these were not always actioned in the records that we saw. In addition, the audit tool was only used on an ad hoc basis instead of all the notes. We raised this with the registered

manager during the inspection and she told us the provider would put plans in place to ensure care records were audited and issues acted upon.

A number of other audits took place which included monthly monitoring of people at risk of weight loss or pressure sores, and an infection control audit. A medicines audit took place June 2016 looking at medicine administration records, controlled drugs and the organisation of the clinic room, observations and stock balance checks.

These audits demonstrated that the management team had a good oversight of the people using the service and the care and treatment plans in place for them.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not receive training, as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)