

Crown Care II LLP

Osborne House

Inspection report

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13 March 2018

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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?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 6 and 13 March 2018 and was unannounced on day one.

Osborne House (the service) is registered to provide accommodation for up to 74 older people some of whom live with dementia. Accommodation is provided over three floors; residential care is provided on the ground floor, nursing care on the first floor and care for people living with dementia on the third floor. The home is set in private secure gardens. There is a car park for visitors.

People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the last inspection, the service was rated Good.

The provider is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager of the service had submitted an application to register with CQC and this was being processed.

The quality of the record keeping varied and some care records we looked at were not personalised and were inconsistent or incomplete. This meant staff did not have an up to date record of people's care and treatment.

The manager of the service was not available to assist us on day one of inspection and the service was being managed by senior nurses and care staff. We found there was a lack of direction under their leadership which impacted on the care given to people. Care was task based although the staff were patient and kind with people. People were sat in the same position for hours at a time, with no interactions from staff. Meals were late going out at lunch time and people told us the meals were cold when they got them.

The regional manager dealt with our concerns on day one of the inspection and the manager took further action when they returned to work. People and relatives gave positive feedback about the service. They said the issues raised on day one of inspection were not reflective of their usual care and treatment when the manager was in post.

People told us they felt safe and were well cared for. The provider followed robust recruitment checks, to employ suitable people. There were sufficient staff employed and on duty that they should have been able to assist people in a timely way. Medicine management practices were reviewed by the manager and medicines were given safely and as prescribed by people's GPs.

Staff had completed relevant training. We found that the nurses and care staff received regular supervision and yearly appraisals, to fulfil their roles effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to talk to health care professionals about their care and treatment. People could see a GP when they needed to. They also received care and treatment from external health care professionals such as the district nursing team and speech and language therapists (SALT).

People were treated with respect and dignity by the staff. People and relatives said staff were caring and they were happy with the care they received and had been included in planning and agreeing the care provided.

People had access to community facilities and a range of activities provided in the service. People and relatives knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been dealt with.

People told us that the manager was approachable, open and honest. People and staff were asked for their views and their suggestions were used to continuously improve the service.

At this inspection we have identified a breach of regulation 17 with regard to poor record keeping.

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

This is the first time the service has been rated as Requires Improvement.

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.

Medicine management practices were reviewed by the manager and action was taken to ensure medicines were managed safely.

The provider had effective recruitment procedures in place. Although there were enough staff to meet people's needs safely staff deployment was not always consistent.

People were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

The service was disorganised at times and people did not always receive consistent care and treatment.

Staff received training, an effective induction and supervision/appraisal.

People's capacity and consent was documented. Deprivation of Liberty Safeguards applications were made appropriately.

People received support to access health care services.

Is the service caring?

Good ●

The service was caring.

People had a good relationship with staff who showed patience and gave encouragement when supporting people with their daily routines.

People said their privacy and dignity was respected by the staff.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

The service was not consistently responsive.

Staff were patient and kind when delivering care, but care records were not always person-centred and care and treatment was not consistently documented.

Staff supported people at the end of their life, but their care plans were not amended to reflect the change in their needs.

People had access to a range of activities and enjoyed those on offer.

There was an effective complaints policy and procedure in place and people felt their concerns were listened to.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

The running of the service under the leadership of the senior nurses and care staff was not effective. Although action was taken by the regional manager during our inspection, the provider's oversight of the service had not identified the shortfalls beforehand.

There was a clear leadership structure with identified management roles.

The manager had submitted notifications to CQC in a timely way.

People, relatives and staff members were asked to comment on the quality of care and support.

Requires Improvement ●

Osborne House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 6 and 13 March 2018. Day one of the inspection was unannounced and we told the registered provider we would be visiting on day two.

The inspection was carried out by one inspector, a specialist practitioner for dementia care and three experts-by-experience on day one of the inspection. The inspector completed day two alone. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and people living with dementia.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams to gain their views of the service. The information we gathered was used to plan this inspection.

During the inspection we spoke with the regional manager, business manager, manager and deputy manager. On day one of inspection the manager was not available so another registered manager from a sister service assisted us with the inspection.

We spoke with seven staff including nurses, care staff, activity and domestic workers, 21 people who used the service, 11 relatives and three visitors. On all three floors we observed care interactions between staff and people who used the service, and observed the lunch time period in the dining rooms. Most people could communicate with us, although some people had communication problems or were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care records, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We also looked at a selection of documentation created as part of the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for five members of staff, staff training and supervision records, risk assessments and accident/incident documentation, policies and procedures and records of maintenance carried out on equipment.

Is the service safe?

Our findings

People told us they felt safe living at the service. Comments included, "I have a call bell and they come when I need them" and "I get my tablets on time." One person told us, "I go out nearly every day, I sign out in the office and again when I come back in so that they know where I am." A visitor told us, "My relative is safe they have a sensor mat near their bed."

People had a high regard for the staff although several considered the level of staffing could be improved. The dependency levels of the people who used the service were used to determine the levels of staff on duty. We looked at a copy of a dependency tool used by the manager and checked four weeks of the staff roster; this indicated there were sufficient staff on duty over the 24 hour period to meet people's needs.

However, on day one of our inspection we found the service was disorganised. Without the manager being present the senior staff on duty did not oversee and direct other staff appropriately. For example, the second floor only had two staff on duty to support 14 people living with dementia, four of whom required two staff to assist them with care.

Care given was task based although the staff were patient and kind with people. We also noted people were sat in the same position for long periods of time, with no interactions from staff. For example, we spoke with one person at 10:15 who had been assessed by the service to have high physical and health needs. They required repositioning by staff every two to three hours. They should have had a positional change at least once between waking and lunch time and to have been repositioned after lunch. There were no records to this effect in their room. When we returned at 13:00 they confirmed that no staff had been in to reposition them.

Meals were late going out at lunch time and people told us the meals were cold when they got them. We discussed our concerns with the regional manager and they reviewed the staffing on each floor immediately. This was addressed by the regional manager on day one. By day two when the manager was back at the service, action had been taken to ensure staff provided consistent care to people. This included talking to senior staff and allocating staff at the start of each shift.

Agency and bank staff were used to cover gaps in the shifts and the manager obtained agency profiles and tried to use the same agency staff for continuity of care. We observed that people were settled and relaxed in the service on day two of our inspection

Staff received training on making a safeguarding alert so that they would know how to follow local safeguarding procedures. Staff told us they would have no problem discussing any concerns with the managers and were confident any issues they raised would be dealt with immediately.

There were care notes and risk assessments in place that recorded how people's identified risks should be managed by staff. These had been updated on a regular basis to ensure that the information available to staff was correct. The manager monitored and assessed accidents within the service to ensure people were

kept safe and any health and safety risks were identified and actioned as needed.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date and had been reviewed in May 2017. Fire safety training for staff and fire drills/evacuation scenarios were planned and carried out at regular intervals over a 12 month period. Personal emergency evacuation plans (PEEPs) for people who used the service were completed and reviewed in January 2018 by the manager. A PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency.

The provider had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

Records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service.

An infection prevention and control audit had been completed and had an action plan in place. We looked at the communal areas and a sample of bedrooms (with people's permission). Premises were clean and there were no malodours. People were very happy with the laundry service with no issues regarding clothing going missing or receiving other people's items. People told us, "It's immaculate, the main housekeeper has very high standards, they have been here since it opened" and, "That's why I chose it (the service). It's very clean."

The arrangements for managing people's medicines were safe. People's medicines were kept under review and medicines were administered to people in a safe way. People were helped and supervised if they needed to be. One person said, "I get my medicines on time. I cannot remember what they are all for, but the staff are very good, very careful."

Is the service effective?

Our findings

Some aspects of the service were not always effective when the manager was not on site. However, people told us they were generally well looked after and did not feel there was an impact on their wellbeing.

There was a lack of organisation by the senior staff on duty on day one of inspection. Staff deployment was poor, which meant some people's care was missed. For example, positional changes were not performed and therefore people were at risk of skin damage/pressure sores.

At least eight people with complex needs were not being given effective pressure relief or positional changes as the documentation recorded there was more than five hours between interactions. On the afternoon of day one staff gave people the pressure relief when asked by us, but this meant that they did not get a mid-afternoon drink as the staff in charge gave no consideration to the carrying out of both tasks.

Feedback was given to the regional manager that two people on the nursing unit did not have pressure sore documentation in place or monitoring documents. Although we saw that the nurse on duty had changed their dressings that day.

We asked the regional manager to address our concerns around the recording of pressure sores and the repositioning of people. When we returned to finish the inspection on day two, we found all these practices had been addressed by the regional manager and home manager. Documentation was in place and being completed appropriately and regular repositioning was taking place.

On day one of our inspection people complained that their food was cold and service was slow. The dining service was more efficient on day two. Menus were written as a four week rolling programme. Those we looked at were seen to be repetitious and lacked choices. We observed that people in bed did not have drinks to hand and people on the dementia unit were not offered a choice of drinks or snacks of the types offered on the other units.

These concerns were discussed with the regional manager at the end of day one of inspection and they assured us action would be taken straight away to improve staff practice and ensure everyone received a good choice of nutrition and hydration. By day two of our inspection the dining room experience for people was much improved and people had access to snacks and drinks both in the communal areas and in their bedrooms. The manager told us that a new chef had been employed and new menus were being created. Feedback from people had been listened to and the main meal of the day was moving from evening to lunch time in line with their requests.

People were clear about how they could get access to their GP and that staff would arrange this for them. One person told us, "Staff notify doctors, they sent for a doctor for me and the doctor recommended I went into hospital. They increased my medication and sent me back."

A visitor said, "I usually take my relative to the hospital. They have not needed a doctor since being here. Staff give them their medicines fine."

We observed that people who stayed in bed had appropriate pressure relieving mattresses and chair cushions in place. Where people were risk assessed as at risk of falls they had sensor mats to alert staff when people moved around and / or crash mats to prevent injury if people rolled out of bed. People were happy with the facilities and equipment available. One person told us, "I have a special bed. The occupational people sent it in; it's adjustable like I had at home. You can bring your own furniture – I've had sky put in."

People told us they felt staff had the necessary skills to look after them. Comments included, "Overall they [Staff] are good, some of the new ones are just learning" and "I cannot say anything wrong about any of the staff." One relative told us, "I'm generally quite pleased with my partner's care and I come in to help them at mealtimes." Other comments from people included, "Staff seem well trained and know what they are doing" and "The staff look after me alright."

Staff who were new to the caring profession were required to complete the Care Certificate; this ensured that new staff received a consistent induction in line with national standards. Agency staff also completed an induction before starting work in the service. A comprehensive training programme was in place for new staff and there was continuing training and development for established staff.

Staff were supported by having regular supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Minutes of the supervision meetings were made available to us during the inspection. Staff had also received annual appraisals of their work performance.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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).

We checked whether the service was working within the principles of the MCA. We found that people had been assessed for capacity, and DoLS referrals were being made to the supervisory body. An overview sheet showed that the manager was monitoring and updating these as needed.

The environment was well maintained with good quality fixtures and fittings. All areas were clean, tidy and odour free. The corridors were wide and mainly straight with no obstacles, making it easy for people to move around if they wished and gave good lines of sight for the staff to identify if people needed assistance. There were some dementia friendly aspects to the environment on the second floor. Bedrooms doors were painted in bright colours and had room numbers and pictures of the people who lived in each room to help people living with dementia to recognise which room was theirs. The corridors were decorated with old fashioned pictures and they also had tactile items such as hats, shoes and scarves. There was seating in the corridors.

There were signs on rooms such as the toilets and bathrooms but these were small signs and some were at low level making them difficult to see. There was some pictorial signage for bathrooms or toilets. There was no directional signage on the second floor to help the people living there to move around independently. However, the floor had a simple layout and the people who lived there appeared able to find their way around. Discussion with the manager on day two of inspection indicated that new signage that was more dementia friendly was on order.

Is the service caring?

Our findings

We found some aspects of care and support were not being delivered on day one of our inspection such as pressure relief and choice of snacks and drinks for people living with dementia. We found the service to be disorganised, but this was much improved on day two.

Discussion with people and relatives indicated that care and support was usually quite good in the service and that our findings from day one were outside of the normal service. One visitor told us, "The staff are very good. I can't complain about them at all, as a whole very good." People expressed the view that generally they were well cared for. Comments included, "The girls are very good", "Staff are lovely" and "The staff look after me alright."

We observed care interactions around the home. Staff were polite and sensitive to people's needs. They knocked on the doors of people's bedrooms before entering. Staff also helped people around the home, including taking them to the dining room or back to their rooms. We observed a nurse encouraging one person to take their medication with patience and friendliness, the person was having trouble swallowing, so they suggested they might try and get some liquid medicine for them.

People were clean and tidy in appearance and one person said, "Staff respect our privacy and dignity." Another person told us, "I must have that, privacy is most important; I always like to do things myself. If I'm not pleased I would definitely say so but it's been perfect up to press." Relatives were satisfied with the care being provided and said, "Staff are friendly, pleasant, deal with issues promptly and have compassion and empathy", "They treat my relative with respect and dignity and they treat us well too" and "If my relative doesn't want to do something they won't, but staff manage them well, they seem to be well cared for."

People had access to call bells and were encouraged to personalise their bedrooms to make them feel more familiar and homely. This included bringing in their own furniture and photographs. We observed that the people who lived there could choose to have their doors left open or closed whilst they were in their bedrooms and staff understood their preferences. One door had a sign saying "Please close the door" as this was the preference for the person living in that room.

Only a few people were aware of having a care plan. One said "I haven't got a copy of a care plan but they do discuss and review it with me." A visitor told us, "Our relative has a care plan and we have been involved on lots of occasions."

Everyone we spoke with said visitors could come any time. One person said "My family is coming at the weekend." We observed and met with several relatives and visitors at different times during the inspection. One person's partner came at lunchtime and stayed all afternoon. Another person's partner visited in the morning, helped with their relative's lunch and read to them in the afternoon. We noted that visitors had access to drinks making facilities on each floor and were able to partake in a meal if they let the staff know in advance.

People told us the staff were caring and understood their needs. Comments included, "They are very good, very thoughtful and know me well" and "Very pleasant most of them." At lunchtime on one of the floors, the member of staff serving lunch clearly knew people well and interacted positively with them. Other staff who were wheeling / accompanying people into the dining room demonstrated a caring manner for example saying, "I'm going to push you in now" and "I'm just going to move your frame a bit, I promise I'll put it back later."

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation was recorded in the care files.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the manager. An advocate is an independent person who supports someone so that their views are heard and their rights are upheld.

Is the service responsive?

Our findings

An assessment was carried out prior to admission, to identify each person's support needs. Care plans were developed outlining how these needs were to be met. Involving people in this assessment helped to ensure support was planned to meet people's individual care preferences.

The quality of the documentation we looked at varied. Not all staff were confident of using the electronic care records including some of the senior staff. This meant some records we looked at on day one of the inspection were not personalised and were inconsistent and incomplete. The majority of files we looked at on day two of inspection were up to date and reflected the care being given on a daily basis to individual people. This was discussed with the manager who said further training was being given to staff.

Concerns were raised with the regional manager on day one that people's complex care needs such as diabetes and Parkinson's disease had no specific care plans in people's care files (where applicable). We saw poor documentation of wound care. For example, two people on the first floor had started to develop pressure sores over the last week and neither was recorded on a care plan, risk assessment or wound care regime. However, discussion with the people and staff indicated treatment was being given. One person did have a body map completed. By the time we returned on day two the wounds had been documented and treatment was recorded. A referral to the tissue viability nurse had also been made for one person.

Four people were receiving 'end of life' care and support. Two people whose care we looked at were seen to be comfortable and settled in their beds. Appropriate care was being given to meet their individual needs. Specialist beds and pressure relieving mattresses were in place and their beds were clean, dry and each mattress was set to their individual weights. Their records showed that they had received input from their GP's and other healthcare professionals as needed. One relative told us, "My parent is receiving palliative care and the MacMillan Nurse comes in to see them. Staff here are 'spot on' at calling for the doctor if needed."

Although we observed staff gave empathetic care they had not developed an individual plan of care and support for end of life, to include physical, psychological, social, spiritual and cultural needs and environmental considerations. On-going assessment and review needed to become a proactive process to take account of and respond to people's changing needs in a timely way.

The above evidence showed that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were satisfied that generally the staff knew what care they needed. People and relatives had been involved in the review process of care and support. People told us they were happy with the care they received and considered it appropriate. One relative said, "Staff do as much for my relative as they need."

There were two activity organisers and there was a weekly programme of activities for each floor. Events were arranged periodically and outside entertainers visited. The activity organisers did not organise trips out

for people apart from when an individual might be taken to the local shops. One person told us, "I prefer to stay in, I find it painful to go out but if I want to, my family can take me out." A relative said "If the weather is good, I give staff 24 hours notice and they get my family member ready so that I can take them out."

A detailed programme of activities was displayed in the foyer which set out the activities due to take place on each floor on every day of the week. The programme indicated who was to lead the activity – activity organiser (named), staff or a resident. Activities listed included 1:1's, crafts, sing along, current affairs quiz, foot soaks, games and films.

Most people were aware of the activities arranged. Two people showed us pictures they had made at a craft day. One told us, "There is sometimes bingo, and a man from outside does some exercises." Another person said, "I'd like more exercise sessions, I can't stand but I need to keep my legs, feet, arms and hands moving." A third person told us, "I go out for a walk everyday if the weather is alright and in the afternoons I'll go upstairs and play dominoes."

People were happy with the service. They felt if they had a problem they would be listened to and knew how to make a complaint. Comments included, "I'd speak to the unit leader or the senior nurse but also feel I could speak to the manager" and "Staff are good at talking to me and clarify things and are very approachable." None of the people we spoke with had made a complaint about their care, but they told us if they had a problem they would speak to a member of staff or the manager.

We observed in the reception that there was a complaints procedure on the wall and information was provided to help people understand the care and support available to them. The records of complaints showed that these were dealt with appropriately by the manager when received.

The manager was aware of the need to make information for people available in accessible formats to ensure people were able to read and understand it. This regional manager told us accessible information would be made available on request, but the service needed to be open with people on how they could access this. This work was on-going.

Is the service well-led?

Our findings

The manager of the service had a good understanding of their role and responsibilities with regard to the running of the service. Despite this, when they were not at the service the senior staff left in charge were not as organised. This impacted on the quality of care given to people and had not been picked up by the provider prior to our inspection. We identified issues with task based care, lack of positional changes, lack of interaction, poor staff deployment and meals being late and served cold.

The regional manager and manager were both quick to respond to our concerns both on day one of the inspection and later when the manager returned to the service. However, the deputy manager and other senior staff had been in charge for a week prior to the start of our inspection. We found that improvements were needed to the documentation of care such as positional changes, food and fluid records, wound care and end of life care plans. The lack of information meant that staff did not have an up to date record of people's care and support needs.

The lack of comprehensive records showed that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager in post. However, the manager had submitted their application to register with CQC and this had been accepted. The manager was supported by a deputy manager, nurses and senior care staff.

The majority of people and relatives we spoke with had been to a meeting with the manager the previous week. Some comments were, "I have met them (the manager). They were extremely helpful, knowledgeable and had time to talk. I was very happy with them", "I've already seen some changes and benefits" and "The manager's very good, they are willing to talk, good organisation, see them every day – every time they come in." One relative said, "I think they are going to be very good, they call a spade a spade, tell it how it is, they won't be fobbed off, and they are honest and approachable."

People and relatives were asked for their views of the service through use of a suggestion box in the entrance hall, meetings and surveys. The majority of people said they had not attended the meetings for a variety of reasons. One person said, "I was aware there was a meeting last week, but chose not to attend." Others told us, "I have not been here long, haven't been here long enough to think about them" and "I missed it, I don't know why, just forgot I think."

One visitor told us, "They did a survey just after the manager came into post. They've been changing things round a little bit, tried to improve the food, chefs don't stay long. I was on holiday last week so didn't make the meeting." Another visitor said, "Last week was the manager's first meeting, it was a good meeting, people had various concerns and the manager addressed them very well. They told us what they intended to do, there were no barriers put up."

The activity organiser told us that at the meeting some people asked that meals be changed round so that

the main meal was served at lunchtime. We observed this was being actioned when we returned on day two of inspection.

People and relatives told us what they thought was particularly good about the service. Their comments included, "The staff and the cleanliness", "The atmosphere, it's friendly on the whole and I know my relative is safe" and "Everybody is well cared for. It is a lovely environment and the staff have people's interests at heart and go the extra mile."

Monthly visits were carried out by the regional manager and the records of these were made available to us. Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in February 2018 and covered areas such as bed rails, complaints, staffing, safeguarding, health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We also saw that audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. □

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

| Regulated activity | Regulation |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | <p>The provider failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided.</p> <p>Regulation 17 (1) (2) (c)</p> |