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Trinity Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
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 1 and 3 March 2016. The first day of the inspection was unannounced; the provider knew we would be returning for a second day. The provider met the Regulations we inspected at their last inspection which took place on 7 July 2014.

Trinity Court Nursing Home provides care for up to 50 people. The home is arranged over three floors and accommodates people for respite, palliative and dementia care. At the time of the inspection, there were 50 people using the service, although one person was in hospital.

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 told us they felt safe living at the home and that the staff were kind and friendly and caring towards them. Relatives that we spoke with also told us they had no concerns about the safety of their family members.

Care workers demonstrated a caring attitude when we observed them during the inspection. They spoke to people in a gentle manner and took their time when supporting them.

Staff supported people with regards to their medicines and people's support needs in relation to health were being met by the provider. They were registered with a GP who visited the service on a weekly basis. Annual medicines reviews also took place. Other health professionals, such as physiotherapists, speech and language therapists and community nurses were involved in people's care and updated care records as appropriate.

People told us they enjoyed the food at the home and told us they were offered a choice in relation to their meals which were prepared using fresh ingredients. The chef had been working at the service for a number of years and was familiar with people's needs.

The provider was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Consent was sought for everyday decisions and where people did not have the capacity to consent to more complex decisions, decisions were made in their best interests, involving relevant professionals.

Staff recruitment at the home was robust and staffing levels were sufficient to meet people's needs. Call bells were answered quickly, however we found that staff were stretched at certain times of the day. This was confirmed by care workers we spoke with and through reviewing staff meeting minutes.

We found that although care plans were reviewed on a regular basis, and were well designed with respect to clinical care, they were not person-centred in all cases. We also found some gaps in the records that we saw, some related to person- centred information and others related to care planning.

The service was well-led. People and relatives told us they knew who the management team were. Staff told us they felt supported. The director and area manager were a regular presence at the home.

Robust quality monitoring took place, including medicine, clinical and health and safety audits. These were completed by the registered manager, area manager and external professionals.

The service demonstrated its commitment to continuous learning and improvement by being involved in a number of schemes, including an accreditation award from the Gold Standards Framework (GSF) for end of life care. The service was a member of the registered nursing home association and attended provider forums in the borough. They were also taking part in a research study by the National Institute for Health Research around helping care home staff to deliver person-centred care to people living with dementia.

During this inspection we found breaches of Regulations relating to care planning. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe living at the home.

Individual risk assessments had been completed for peopling using the service and these were reviewed on a regular basis.

Medicines management at the home was robust.

Staff recruitment checks were robust. Staffing levels at the home were sufficient, however there were periods in the day where staff were under pressure to deliver care in a timely manner.

Is the service effective?

Good

The service was effective.

Mandatory training was delivered to staff on a regular basis.

People had their healthcare and nutritional needs met.

The provider was meeting the requirements of the MCA and DoLS.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and respected their privacy. Staff maintained people's dignity when carrying out personal care.

Care workers spoke to people in a friendly manner, took their time and did not rush them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Some care records were not fully completed and lacked person-centred information.

A range of activities was on offer at the home, which people told us they enjoyed.

Complaints were responded to a in a timely manner.

Is the service well-led?

Good

The service was well led.

Staff told us they felt supported and said the registered manager was approachable.

Quality assurance audits to monitor the quality of the service were comprehensive. These included medicines, health and safety and clinical audits.

The provider demonstrated its commitment to continuous improvement through a number of schemes it was involved with.

Trinity Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 3 March 2016. The first day of the inspection was unannounced; the provider knew we would be returning for a second day.

This inspection was undertaken by one inspector, 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 trained mental health 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, four friends/relatives and 14 staff members including the director, the area manager, the registered manager, the deputy manager, nurses and care workers. We also spoke with a chef, domestic staff and a handyman. We looked at records including five care records, training records, four staff records, complaints and audits. We also contacted eight health professionals after this inspection to gather their views, we heard back from three of them.

Good

Is the service safe?

Our findings

People using the service told us they felt safe living at the home. People's comments included, "Yes, it's safe here" and "Yes, I know where everything is", "[Staff] are really nice" and "I have a call bell which is answered within five minutes and the staff help me with anything I need as I can't leave my bed."

A care worker told us, "If you have any concerns, you can go to any of the nurses. They will take it on board." Another care worker said, "They are safe. They get good care." When another care worker was asked what they would do if they witnessed poor care, they told us they would report it to their manager and demonstrated that they understood their responsibility to protect people from harm.

Some people were in bed and the use of air mattresses was common throughout the home. The handyman helped ensure these were in good working order, referring to the manufacturer for problems beyond his expertise. The use of the standing hoists was evident in the day room, and staff reported that all the equipment worked. Interaction with people during hoisting procedures was respectful and clear. A member of staff who had less experience of the hoist requested help from a colleague to ensure a safe technique.

Staff files contained evidence of appropriate checks on staff before they started working at the service. This included an application form, copy of their passport, national insurance number, two references and criminal records checks.

We asked people if they felt there were enough staff available at the home. They told us, "There is enough staff", "Don't have any problems calling staff at night", "Yes in the daytime and no at night. There is hardly anyone around at night" and "Staff members can always help me, or get someone else that can."

We reviewed the staff rota for a three week period, from 15/02/2016 to 6/3/2016. There were two nurses on shift during the day and one at night. There were between seven and nine care workers on during the day and between three and four at night. On some occasions there were six care workers on during the day at weekends.

During the day of our inspection there were two nurses, nine care workers, and an activity coordinator on shift. These were allocated to each floor, with two care workers on the second floor supporting 15 people, three on the first floor supporting 20 people, two on the ground floor supporting 15 people, with one floating care worker and another based in the lounge on the ground floor.

Some care workers raised some concerns about the length of time it took to manage people's personal care needs. On the first day of our inspection, some people were still being supported with their personal care at 11:00. The day shift started at 08:00 and breakfast was served at 08:30. Care workers told us some people had to wait until after breakfast for personal care. One care worker said, "They all need help with personal care and feeding, it can take a long time." Another said, "Doing personal care can sometimes take us up to lunchtime." One member of staff said some days they did not always get everything done but the work was prioritised on busy days or if there were staff shortages at short notice.

These concerns were raised by staff in staff meeting minutes that we saw. Staff said they could generally get through a shift's work if there were no untoward incidents or unexpected staff shortages. In general staff worked in pairs. However, on some occasions colleagues were not always readily available to assist people with chair transfers in the day room.

The registered manager and the Director told us they were aware that personal care was taking a long time and they constantly reviewed staffing levels. We were told that management were considering staggered start times to ensure that more staff were available during times of greater need. The registered manager explained there was no prescribed formula for staffing ratios but they timetabled in advance for the minimum number of staff required on a daily basis.

People were assessed with regards to their level of dependency in a number of areas, including mobility, breathing, nutrition, skin integrity, dressing, bathing and oral hygiene. These assessments were reviewed monthly to ensure that any changes in people's needs and the level of support they required were reflected.

Risks to people were assessed through a number of standard tools, for example moving and handling assessments, falls assessments, tissue viability, Malnutrition Universal Screening Tool (MUST) and Waterlow. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. Waterlow is a tool used to assess the risk of a person developing a pressure ulcer. The Waterlow consists of seven items: build/weight, height, visual assessment of the skin, sex/age, continence, mobility, and appetite, and special risk factors, divided into tissue malnutrition, neurological deficit, major surgery/trauma, and medicines.

These assessments were reviewed on a regular basis which meant people were consistently assessed to monitor any risks to their safety. Where people were identified as being at high risk, associated care plans were in place to further support people and manage the risk to protect people from harm.

People told us they had no concerns about their medicines, telling us "I get tablets every day at about the same time", "Medication is always regular and on time" and "Yes I get them three times a day. Staff are reasonably good at coming on time."

The medicines system was efficient and effective. Medicines administration record charts were carefully completed and easy to follow. Colour coded blister packs contributed to safe administration. There were no known errors made in the last year. There was a guide to administering medicines to people, including body language and recommended styles of communication. Allergies were immediately identifiable and prominent on the charts. People with swallowing difficulties were also clearly indicated.

The clinical room was compact, clean and tidy. The fridge and room temperatures were up to date and showed that medicines was stored at an appropriate temperature.

Two people had been prescribed a medicine which required careful and regular blood monitoring. There was a timely and efficient system in place for this and the subsequent retrieval of medicines. Some nurses, including the registered manager were trained in phlebotomy.

The home was not always free from odours. There was a faint but noticeable incontinence smell on first entry to the home, possibly accumulating in the fabric of the building over time, carpets and chairs in particular. The fabric of the environment in general was showing signs of wear. One person said they preferred to avoid some chairs in the day room as they thought they smelled. Some notices were cello taped on walls which added to a bit of untidiness.

Good

Is the service effective?

Our findings

People told us that staff were skilled and well trained, "Staff are definitely well trained", "Never have problem with staff not knowing what to do" and "It's good." However, we found that staff were not always provided with adequate training to ensure that they had the skills and knowledge to meet people's needs effectively.

Care workers had completed an induction in which the following topics were covered, infection control, safeguarding, the Mental Capacity Act and Deprivation of Liberty Safeguards, food hygiene, mental health, communication, nutrition, dementia, health and safety, end of life, first aid, fire safety and care giving.

The registered manager told us that safeguarding training, moving and handling and infection control needed to be renewed every two years. We asked the registered manager to provide us with an up to date training matrix which we received after the inspection. We saw that staff were up to date with their training and we checked the relevant training records and spoke with staff who confirmed the training they had received.

There was a significant proportion of people with historic mental health conditions; at least 20% with a history of schizophrenia. Several other diagnoses included Bi-polar disorder, epilepsy, depression and anxiety, Asperger's and Korsakoff's. Staff knowledge of mental health conditions other than dementia was variable. There did not appear to be an emphasis on training staff in mental health or psychological well-being.

Staff received supervision every two months with their line manager and also had annual appraisals. Care workers told us, "The nurses are helpful", "It's a nice place to work, everyone is helpful" and "[the registered manager] is good, we can talk to her."

A relative told us they were kept informed about changes to their family member's health. People told us that staff helped them to manage their pain, "I get painkillers if it's bad" and "I get given pain medication to help and they take me to the doctor's if it gets too bad."

We observed the mid-day staff information handover. Care workers reported to each other and the nurses on the progress from the morning's work. There was a routine system of reporting and the overall emphasis was clearly on physical care, including elimination and skin integrity. Monthly records were kept of people's blood pressure, pulse and weight.

There was one Registered Mental Health Nurse in the qualified staff team and an in-house physiotherapist worked at the service three days during the week and was observed to work as part of the team. Physiotherapists demonstrated moving and handling techniques and on occasion were asked for assistance and advice from care workers. Physiotherapists recorded their sessions with people in their care records.

Other mental health professionals visited from NHS community teams, including a psycho-geriatrician and

community psychiatric nurses. These professionals visited on request and had a section for recording in people's notes. An aromatherapist visited once a week and included massage in her interventions. GPs and a Tissue Viability Nurse visited as required.

A GP visited the service twice a week and reviewed people that were not feeling well. Staff completed a doctor's book with those people that needed to be seen and we saw documentary evidence that the doctor saw these people and completed notes recording what action had been taken. The GP also carried out a medicines review every six months and a general health check every year.

Each person had a 'personalised care plan', a document produced by the GP which was sent with them in case of a hospital admission. This had their medical information, results of any previous investigations, a record of significant past medical history and their prescribed medicines. Each person also had a hospital passport in place, containing more personalised information related to people's preferences.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found that staff understood their responsibilities under the Act. Some people had a DoLS authorisation in place at the time of our inspection, we reviewed the paperwork in place for them and saw it was all in order. Other people told us they were able to leave the home, either with staff support or on their own. They told us they did not feel restricted in the home. A care worker told us, "You have to try and offer them choices, ask them their preferences." Another said, "You have to respect their choices, if they refuse personal care, you cannot force them."

We asked people what they thought about the choice and variety of food and if they were able to get a drink or snack when they wanted. People said, "It's nice, they ask what you want for the day", "We can have a main meal or sandwiches. Yes like a normal breakfast is cornflakes and tea or coffee but this morning I had bacon sandwich and tea", "It's reasonable", "They usually bring something round every few hours."

The menu was written down on a noticeboard in the lounge area, it was also displayed in pictorial format. We noted that the pictorial menu differed from that which was written down. This may have caused confusion for some people. People's dietary requirements, for example those with diabetes and their preferences were also on display. Swallowing guidelines from the Speech and Language Therapy (SALT) team were also on display for staff to refer to. Some personal dietary information was on display in the main lounge, which did not protect people's right to privacy as other people could view this personal information.

People were offered a choice of meals to eat, including a vegetarian option. The chef told us people were entitled to request food other than that which was on the menu if they felt like it. They told us there was always plenty of alternatives available. We saw the dry food store, all the items were within date and it was clean. We did however see some items in the fridge that were past their use by date, we pointed this out to the chef who immediately disposed of them. Other items in the fridge were labelled with the date they had been opened so that staff could tell if they were still safe to use.

The kitchen area itself was clean, although the dishwasher was broken on the day of our inspection and the kitchen assistant had to wash all the breakfast cutlery and crockery by hand. Fridge and freezer temperatures were recorded and cooked food was temperature checked with a probe to ensure it was fully cooked.

A food hygiene inspection check had taken place in April 2015 and awarded the service the highest rating of 5.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Comments included, "Staff are busy here, there everywhere doing stuff. But they are always polite and try to do their best", "Yes never had any issues", "They take care of all my needs" and "They are nice." A visiting relative said their family member was content living at the home. Other relatives said their family member was "Well looked after. [They] are happy here" and "Staff are friendly, they are caring."

Relatives were welcome in the home and several were seen on the day of inspection. A notable respectful activity was the 'Remembrance Day' held yearly to remember deceased people. Relatives were invited to have a sandwich and a cup of tea and remember their loved one with staff support. A relative told us they were able to visit at any time and on birthdays, the provider gave them access to the conservatory so extended family and friends could visit and join in the celebrations.

Several incidences of good practice were observed. Staff were calm and talked to people at eye level and engaged in clear conversation to determine the wishes of people. One example was a person being unsure if they wanted tea or coffee, or something else to drink. The care worker spent time patiently and reviewed the options available until they had negotiated a choice. We also observed staff responding promptly and sensitively to someone who was taking off an item of clothing in the day room so that their dignity was protected.

The lunch time meal was observed and all staff took part to assist with those who required help. The atmosphere was busy but peaceful and had a sense of community. However, we noted that some people had to wait over 20 minutes from when they first sat down to when they were given their lunch, this was because the handover finished at 12:35 and staff were only free to go and support people with lunch after this had finished. One care worker sat down with one person and was trying to help them eat. They allowed the person time to eat, giving them attention and not rushing them.

The staff team in general had a calm and responsive manner. Despite the high level of care needed and the time required to complete routine tasks, staff appeared focussed and responsive. Staff were all pleased to speak about their work if asked. People were addressed and treated with notably caring and respectful attitudes. People were addressed by their proper names and despite sharing a large day room, the interactions were person centred and discrete.

People told us that their privacy was respected. They commented, "I can't recall any time it wasn't", "They help me get changed but they always tell me what's going on and wait for me to say what I want to do" and "They knock on the door and wait."

People's cultural needs were considered, and we noted that there was a range of faith related visits. There were occasional services for Christians, including Holy Communion. People from different faiths were also supported to go to their preferred places of worship if they wanted to. Some culturally appropriate food was prepared if requested by people.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not always sufficiently detailed to ensure that they received person centred care that met their individual needs. For example, one section for people's 'likes and dislikes' and 'strengths and weaknesses' had an entry which indicated the person was not able to comment and so there was no information available. Staff had not taken the time to record what they knew about the person's likes and dislikes from their observations and experience.

Care workers told us they did not have much input into care plans, apart from completing personal care records such as turning or food and fluid charts. Some expressed to us they would like to be more involved when care plan reviews took place and felt they could offer valuable information on people's emotional well-being on a day to day basis.

Whilst the staff handover was comprehensive in terms of physical needs, little or no reference was made to psychological well-being. At best this was addressed by a general 'no problems' comment.

Care plans contained a front sheet with details of people's next of kin, their past medical history, contact details of their GP and their named nurse and key worker.

Long term care plans consisted of five areas. These were cognition, psychological, physical, social and end of life. These areas were further divided into detailed areas such as memory, communication, emotional, personality, eating/drinking, oral health, social interests, likes/dislikes, future wishes and concerns. These were reviewed every six months.

There were individual short term care plans for people and each care plan had an assessment of their needs, goals/expected outcomes, and the interactions and support required. These care plans were reviewed monthly and updates documented in the section 'interactions and support required'.

Although these were reviewed regularly, we found in some cases not all of the specific areas were completed and there were gaps in some of the records that we saw. For example, one person admitted in May 2015 did not have their six month care plan review, none of the care plans we saw were signed by the person using the service even though they had the capacity to understand what was written in them. In another example, the mental capacity assessment was blank. Other records indicated that this person did not have capacity and there was a deputy appointed by the court of protection to manage their affairs. Some keyworker notes were incomplete and not being done at the expected monthly frequency. However, we saw that the daily reports were being done.

Another person had been referred to the Tissue Viability Nurse (TVN) who reviewed them and advised that a 'strict turning chart is maintained'. We saw that turning charts were only in place for three days since the 15/02/2016. We spoke with nurses and to the person who both told us the wound was improving and the person was turning themselves. However, there was no documentary evidence recording that this person was able to turn themselves and when they had started to do so.

One person was identified as being at high risk in relation to oral health, their score was 'four' which indicated 'completely unable to maintain oral hygiene without assistance'. However, their oral health section of the long term care plan was incomplete. In addition, they did not have an oral health care plan that was reviewed monthly. They did have one for personal care but this did not make any reference to the support needed in relation to oral health.

One person had four falls since May 2015, however their mobility dependency profile was scored 0, indicating they were fully mobile.

This person did not have a Waterlow risk assessment. A nurse told us, "Every patient should have a Waterlow. Maybe it has been overlooked." One person at risk of weight loss had been reviewed by a dietitian and was on a fortified diet. Staff were required to complete food and fluid charts for this person. We saw there were some gaps in these records, with staff signatures missing and incomplete information relating to continence. The individual record sheets were also on loose paper.

The issues identified above were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

None of the people we spoke with raised any concerns to us. A relative told us "No complaints all that is necessary they will do right away."

There was a complaints, compliments and suggestions box but no template for these forms of communication, and the box was not in the most prominent position to encourage use. There was evidence of compliments on display but some of these were not dated.

We reviewed a record of complaints over the past year. There had been five recorded complaints since January 2015. Complaints included issues related to food, personal care needs and complaints against other people using the service. All the complaints received were resolved satisfactorily and the complaints book included details of what action was taken to resolve the complaint.
Relatives told us they were invited to meetings, "There's one on the 15th I will be coming to and I try to come to as many as I can", "The first one is coming up soon that I want to attend. I'm looking forward to meeting all the new people."

People told us they took part in activities that they enjoyed, telling us "They are always doing things but I like to sit here and watch", "I like it when my brother comes and he can take me out. Other than that I don't feel like taking part", "I knit all the time" and "Yes, I like to read the Sun which a staff member brings around. I also like it when we get together and sing." However one relative said their family member spent a lot of time in their room and was at times bored.

The daily activities were regarded as very important and many examples of good practice were evident. There was a range of activities to suit all abilities and interests. The activity coordinator on the day of the inspection was very enthusiastic and took pride in the benefits of activity. On the inspection day there was a gentle exercise group and use of the 'mystery box' where people guessed what was in the box. There was a clear regard for the importance of mental stimulation.

If possible, people went out of the home for short trips in the locality. People in wheelchairs were included in these outings. There were days for lunch clubs, trips to restaurants, walks, and a range of different music events in the home. Guest musicians came regularly to play live music. Staff commented how much people enjoyed activities, particularly the restaurant outing, "People love it and we make sure everyone who is able

to go out gets the opportunity."

There were regular art activities and work completed by people was kept in a display folder, along with many photographs of people enjoying other activities. Groups of local school children and a teacher visited regularly on Friday afternoons to chat with people and serve afternoon tea.

Good

Is the service well-led?

Our findings

People told us they knew who the managers were, "I make sure I do get in touch with them", "They walk around here most of the time chatting with me", "I don't remember her name but we see her all the time." One relative told us, "When we were looking at this place we got in touch with her. She sat down with us and answered all our questions. She was lovely and very knowledgeable."

We asked people what the service did well. They said, "I rather like everything here", "It's very good, can't say anything bad about it." Relatives told us, "They look after her, make sure she is eating. In here she's put on weight and it looks good" and "The sitting area is facing the nurse's station so they can always see what's going on and help when needed."

The Managers were described by staff as "good" and "friendly". Staff appeared comfortable with the presence of senior managers in the midst of daily caring activity, and the managers identified with people and spoke with them directly in a knowledgeable and caring fashion. A care worker told us, "[The registered manager] is very good. This is a good place to work."

The Director and Area Manager introduced themselves on the day of inspection. They were regular visitors throughout the week. The Director attended and was involved in all provider forums to keep up to date with any ongoing developments and ideas being used by other providers to be implemented in the service.

We spoke with the area manager who told us they visited the service two or three times a week to check medicines, care plans and the environment. Formal audits were completed every two months, looking at premises, personnel issues, finances, staffing issues and records. Actions were assigned to the registered manager to follow up on these.

The provider was registered with a number of organisations that demonstrated a commitment to improvement. They had received an accreditation award from the Gold Standards Framework (GSF). GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life. They run training programmes that help to support all people approaching their last years in any setting.

They were a member of the registered nursing home association and were also taking part in a research study by the National Institute for Health Research called Enhancing Person Centred- Care in Care Homes (EPIC). This is a study looking at whether Dementia Care Mapping (DCM) is effective and cost effective for helping care home staff to deliver person-centred care to people with dementia. DCM is an observational tool that helps trained staff (called mappers) look at the experience of care from the point of view of the person with dementia. This information is then fed back to the whole staff team, who work together to create action plans for improvements. Two staff members had visited the University of Bradford for training in preparation for this trial. A researcher was present and undertaking observations on the day of inspection.

Resident meetings were held every two to three months. We reviewed the meeting minutes since March 2015 and saw that between seven to 12 people attended each meeting along with the registered manager,

chef and the activities co-coordinator. Topics of discussion included activities, food, ongoing events at the home such as a dignity day and what it meant and research taking place in relation to person-centred care. We saw evidence that the provider took action when people had requested certain things such as a canopy for smokers.

Staff meetings were held regularly, these were attended by the Director. Topics of discussion included health and safety, staffing issues and infection control. Care workers were given the opportunity to raise any areas of concern. The minutes showed good participation and two-way communication between staff and management. Following the general staff meeting there followed a meeting for the qualified nursing staff.

The provider kept accident/incident records; these included a description of the event, the action taken, who was contacted and the outcome. Many of these incidents related to falls that had taken place. In the records we saw, not all sections were always completed such as the action taken and whether the GP and relatives were contacted.

Health and medicines audits were completed monthly by the registered manager, looking at the occurrences of chest infection, UTI, eye infections, pressure sores, falls and medicines errors on a month by month basis. A pharmacist medicines audit carried out in January 2016 did not identify any concerns. A contract monitoring visit from the local authority took pace in March 2015, no major issues were identified.

Feedback was sought from stakeholders. Questionnaires were sent to people, visitors (relatives and friends) and professionals in April 2015. 28 people, nine visitors and six professionals responded to the survey. Feedback from these was positive.

A full-time maintenance engineer carried out a number of health and safety checks around the home which were all current. These included checks on the bathrooms, bedrooms and other areas of the home, water temperature checks, fire doors, fire alarm, fire extinguishers and emergency lighting. External checks, and current certificates were seen for gas safety, electrical installation, fire certificate, hoists and lifts servicing.

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 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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate and did not always meet service users' needs. Regulation 9 (1) (a) (b).