Care Quality Commission

Accredited Care Limited

Meadows Sands Care Home

Inspection report

98 South Parade
Skegness
Lincolnshire
PE25 3HR
Tel: 01754 762712

Date of inspection visit: 08 September 2015
Date of publication: 03/12/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Meadow Sands Care Home 08 August 2015. This was an unannounced inspection. Our last inspection took place on 04 February 2014. The service provides care and support for up to 26 people. When we undertook our inspection there were 21 people living at the home.

People living at the home were older people. Some people required more assistance either because of physical illnesses or because they were experiencing memory loss. The home also provides end of life care.

There was no registered manager in post. The post had been vacant since May 2015. A registered manager is a person who has registered with the Care Quality Commission (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 current manager had submitted their registered application to CQC and were awaiting an interview.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered

Summary of findings

necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of our inspection there was no one subject to such a restriction. Staff had not implemented the MCA guidance correctly and had not recorded how decisions had been reached.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the lack of information on how decisions had been reached for people who could not make decisions for themselves. You can see what action we told the provider to take at the back of the full report.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period by observations and talking with people who used the service and staff. There was no formal recording of how decisions had been reached.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. And meals could be taken in a dining room, sitting room or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse, but had not received any formal training, except on induction. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements. However, there was no analysis of audits or feedback forms so the provider did not know whether suitable actions had been taken by staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs. However, the manager did not have any method of reviewing staffing levels.

Staff in the home knew how to recognise and report abuse to the manager, but had not received any formal training except on induction.

Medicines were stored and administered safely. Record keeping and stock control of medicines was good.

Requires improvement

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

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job. However some topics required to be updated especially around health and safety and first aid, which had only been covered on induction.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff, but not correctly implemented.

Staff were able to identify people's needs and recorded the effectiveness of any treatment and care given.

Requires improvement

Is the service caring?
The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Good

Is the service responsive?
The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were planned into each day. Staff had recorded if people did not want to pursue individual interest or hobbies.

People knew how to make concerns known and felt assured anything raised would be investigated in a confidential manner.

Good

Summary of findings

Is the service well-led?

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Checks were made to review and measure the delivery of care, treatment and support against current guidance. However there was no analysis of those audits to ensure staff understood good practice guidance and the wishes of people were adhered to.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

Requires improvement

Meadows Sands Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 09 September 2015 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We also spoke with other health and social care professionals before and during our visit.

During our inspection, we spoke with five people who lived at the service, a relative, and three members of the care staff, a cook and the manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at four people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and questionnaires which had been sent to people who used the service.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. They said staff handled them safely and they had confidence in the staff. One person said, "I feel very safe here." A relative told us, "I feel confident [named relative] in leaving them here."

Staff were able to explain what constituted abuse and how to report incidents to the manager should they occur. They did not know the processes which were followed by other agencies, but told us they felt confident the manager would take the right route to safeguard people. Notices were on display in staff areas informing staff how to make a safeguarding referral. Only one staff member could remember having training on this topic. The training records confirmed that all staff had not received safeguarding training except as part of their induction programme. This could mean they were not fully aware of what constituted abuse and how to protect people.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was no process in place for reviewing accidents, incidents and safeguarding concerns. This could result in any changes to practice by staff or changes which had to be made to people's care plans were not passed on to staff.

To ensure people's safety was maintained a number of risk assessments were completed for each person and people had been supported to take risks. For example, risk assessments were in place when someone had frequent falls due to poor mobility and wanting to exercise their independence to walk unaided. Advice had been sought from other health care professionals and the correct walking aids and shoes had been recommended. Where some people were suffering from illnesses such as diabetes which affected their health and well-being, staff maintained records to ensure they were eating correctly, their blood sugar levels were normal for each individual and they observed them throughout the day.

Plans were in place for each person in the event of an evacuation of the building. These gave details of how people would respond to a fire alarm and how they required to be moved. For example being able to walk unaided. A plan identified to staff what they should do if utilities and other equipment failed. Staff knew how to access this document in the event of an emergency. The fire and rescue service had made a visit in August 2014 and made some recommendations. These had been completed and the fire officer had revisited to ensure the building was safe and the fire risk assessment had been updated. However, we did see three doors which were wedged open which contravened the home's policy. They were immediately removed.

People told us there were adequate staff on duty to meet their needs. One person said, " The staff are always there for me." Another person said, "I do a lot for myself, but know staff can and will help me day and night."

Staff told us there were adequate staff on duty to meet people's needs. One staff member said, "Generally there are enough staff. We get busy times; it all depends on what the people we look after want to do." Another staff member said, "Yes and no. Yes if everyone turns up for work, but the manager is good and comes at the drop of a hat. No, if we have to do cleaning jobs if they are short in that department." The cleaning work was completed as extra work from care staff's normal duties.

We saw on the staff rota the numbers of staff stipulated reflected the staff on duty that day. The manager could not show us how they had calculated the numbers of staff required or how they would adjust staffing levels. The manager told us the staffing levels were based on their observations, knowing the peoples' needs and talking to staff. They did not record that information. However, people told us their needs were being met at the moment.

We looked at three staff personal files. Staff recruitment practices were in place and staff had not been allowed to commence work until adequate safety checks had been completed. Staff records were kept securely and accessed only by the manager and provider.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. This had been explained by GPs', hospital staff and staff within the home. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

The medicines trolley and cupboard were clean. However, the medicines storage room was untidy and the light did not work so staff could not see what they were doing. Although a notice stated the room should be locked at all

Requires improvement

Is the service safe?

times, it remained unlocked during our visit. There was good stock control. However, no temperatures were recorded to ensure the medicines were stored in suitable conditions. This would ensure the stored medicines were safe to use. This was discussed with the manager and rectified immediately.

We looked at four people's medicine administration records (MARS) and found they had been completed consistently. Details of changes made by GPs' had been recorded. Two records within a required register for some medicines had not been accurately recorded. Staff were able to explain the reasons for the entries. The stock balance was correct.

We observed medicines being administered at breakfast time and lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff stayed with each person until they had taken their medicines. Staff who administered medicines had received training. The certificates were shown to us. The manager was looking at appointing more night staff to train to administer medicines as it was sometimes difficult to ensure suitably trained staff were able to cover the night time period.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

Staff were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. All permanent staff had undertaken training in the Mental Capacity Act 2005 in 2014. New staff, some ancillary staff and bank staff had yet to complete their training. The rest had this planned into their training programme for 2015.

Staff told us that where appropriate capacity assessments would be completed with people to test whether they could make decisions for themselves. There was no evidence of this in the care plans. The manager told us this went on observations of people, but they did not write them down. The manager had submitted 19 applications for people to be subject to DoLS authorisations. We saw the details of those submissions but not how the decisions had been arrived at before the forms had been sent. There were no records of decision making meetings or assessments on individuals.

We looked at the Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) forms for two people who could not make decisions for themselves. Both were invalid as some of the sections had not been completed. There was no evidence to show how the decisions had been reached for those forms to be in place and whether they were now required. The care plans did not indicate that either person was nearing their life's end. The forms did not indicate whether the people wishes had been taken into consideration and were able to consent to these actions. The manager took immediate actions to consult with the people's GP.

These matters were a breach of Regulation 11 (3) of the Health and Social Care act 2208 (Regulated Activities) Regulation 2010.

One staff member told us about the introductory training process they had undertaken when they started. This included assessments to test their skills in such tasks as manual handling and bathing people. They told us it had been suitable for their needs. Two new staff had recently commenced work on the new Care Certificate which helps staff to gain a better knowledge about their work.

Staff said they had completed training in topics such as basic food hygiene, infection control and manual handling. They told us training was always on offer and it helped them understand people's needs better. The training was predominately computer based, which staff told us they were encouraged to complete. The training records supported their personal comments. Some staff had completed training in particular topics such as dementia and coping with aggression. The training planner was sent to us after the inspection. This showed some gaps in staff training particularly in topics such as health and safety and first aid, which could mean staff were unaware how to react appropriately in an emergency situation.

We saw the supervision planner for 2015. This gave the dates of when supervision sessions had taken place. Staff confirmed these had occurred. Staff told us they could express their views during supervision and felt their opinions were valued. The provider did not have a supervision policy so we could not tell whether the sessions recorded met staff and company needs.

People told us that the food was good and they had choices each day. One person said, "The food here is lovely. I'm never hungry." Another person said, "I have a medical condition so need regular meals, which I get. It's plentiful." A relative told us they were always offered refreshment when they visited and had observed their family member having meals. The said, "I nearly booked myself in just for the food. It looked lovely."

We observed the lunchtime meal in the dining room. We saw the meals were presented well. They had been placed on plates before being presented at the tables. There was a lot of social interaction between staff and people eating their meals. Staff served the meals; ensuring people also had hot or cold drinks of their choice. People were offered condiments to use, plus second helpings if they wanted

Requires improvement

Is the service effective?

them. The menu was on display in the entrance to the dining room. Staff said this ensured people could see it and remind themselves of the menu choices throughout the day.

Those people who required assistance to eat their meal were given them in their bedroom areas or in a separate dining area. We heard staff explaining what was on plates, for those with limited sight and encouraging people to eat and drink. People told us they were asked about meals by the cook and in questionnaires. We saw the daily records in the kitchen when staff had asked people about their daily menu choices. The kitchen staff kept records about people's personal preferences for food and what they were allergic to eating.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their weight and when a person required a softer diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. Staff told us each person's dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans.

People told us they felt involved in the monitoring of their health. They said they were asked whether they wanted treatments and knew they had the right to refuse or ask for extra help. One person said, "I am happy to call my own GP and do so, but make sure a staff member is near in case he wants other information." People told us they can get to see a doctor or nurse quickly. This was confirmed by two health care professionals we spoke with during the visit who told us staff contacted them when people's needs changed

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to walk with a frame to help their mobility. We heard staff speaking with relatives, after obtaining people's permission, about hospital visits. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made.

The home had set up a system with the local GP surgery of nurses and GPs' visiting regularly. Staff told us this ensured the nurses and GPs' could plan the visits and follow up quickly on new treatments. A health professional's visit was taking place during our visit. Staff had all the information available to ensure the session could run smoothly.

Good

Is the service caring?

Our findings

People told us they liked the staff and they were confident staff would give them good care. One person said, "I get such a lot of help. The staff are lovely." Another person said, "We've had some new girls but everyone is nice."

The people we spoke with told us they were supported to make choices and their preferences were listened to and they were treated with respect. One person said, "I do what I like when I like." People told us there were no restrictions placed on them and they knew they could have a bath or shower when they liked. Individual needs were recorded in the care plans.

People told us they were happy living at the home. They told us they liked the staff and said if they required to see a doctor or nurse staff would respond immediately. One person said, "The nurses come every week so if I want to see them I just ask." They felt the information staff held about them was kept confidential.

People and their relatives told us staff were caring and kind. All were full of praise for the staff. One person said, "The staff have so much patience, its' remarkable." People told us they were treated with dignity. One person said, "Even when helping with the most personal tasks staff treat me with dignity and ask me if everything is alright."

The relative we spoke with felt involved and fully informed about the care of their family member. They said the staff were kind, courteous and treated the people with respect. One relative said, "I can speak to any staff member." They said their family member was being encouraged to be as independent as possible, which they helped to encourage as well.

All the staff approached people in a kindly, non-patronising manner. They were patient with people when they were attending to their needs. For example, one person wanted to walk around most of the day and ask questions of the staff. Each time the staff were patient with the person, answered the questions and tried to divert them to another activity.

We observed staff ensuring people understood what care and treatment was going to be delivered before commencing a task, such as helping with a bath, ensuring people knew when meal times were about to commence and assisting each other to attend to someone resting on their bed.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, staff knew when a person wanted to return to their bedroom after lunch. Staff ensured they were in a safe environment and we saw they made visits to them during the rest of day.

Staff knew the people they were caring for and supporting. They told us about people's likes and dislikes. For example, when they liked to get up in the morning and when they liked to dress or remain in their nightwear. This was confirmed in the care plans. Practical action was taken when people were distressed. We observed not just care staff, but ancillary staff responding to people who were worried and anxious. If they could not answer a person's query the manager was called to assess each situation. One person was anxious about a hospital appointment. Staff explained what would happen and reassured the person they would not attend on their own if they did not want to.

Staff responded when people said they had physical pain or discomfort. When someone said they were in pain, staff gently asked questions and the person was taken to one side and given some medication. When the call bell was sounded we saw staff respond to the person's need. As soon as possible the minimum amount of staff stayed with the person, not to frighten and worry them.

People told us visiting was unlimited and they could invite friends and family at any time. One person said, "I have frequent visitors and they are always welcome." A relative told us, "I like to come later in the day. I know [named relative] will be up and I'm always made welcome."

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the

Good

Is the service caring?

local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display.

People had access to a sitting room area, a dining room, and quiet areas in corridors and an enclosed garden area overlooking the sea front. We observed staff asking people where they would like to be, if they required assistance to move about the building. Staff ensured each person was comfortable, had a call bell to hand and had all they required for a while. This was sometimes a book; we saw a person knitting or the daily newspaper. Other people we observed walked or used a wheelchair to access various parts of the home and grounds.

Good

Is the service responsive?

Our findings

The people we spoke with told us staff responded to their needs as quickly as they could. One person said, "If I need help, I press my call bell and they reply quickly, even at night."

People told us staff had talked with them about their specific needs, but this was in the form of conversation rather than a formal meeting. They told us they were aware staff kept notes about them and a relative informed us they also knew this. They told us they were involved in the care plan process. Care plans were kept electronically and on paper records. We looked at both. However, some records had not been dated in the paper records, such as reviews about needs. The computer records always generated dates, the staff member inputting the data and what type of record. These confirmed when reviews had taken place. The manager was aware of the risk of keeping both types of records and explained new ways of simplifying the system they were using to ensure accurate records were kept.

People told us staff tried to obtain the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, where someone's behaviour was challenging to others, the community mental health team had been involved in discussions with the person, their advocate and staff.

Staff received a verbal and written handover of each person's needs each shift change so they could continue to monitor people's care. We did not see the handover during our inspection; however the records confirmed a previous day's handover. This gave staff details of extra needs of people, such as needing to ask someone about their toileting needs, fluid intake charts to complete and health care professionals to call. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. Health and social care professionals we spoke with before and during the inspection told us they knew staff gave person centred care as they were asked for their opinions about people and staff followed instructions from them.

People told us there was an opportunity to join in group events but staff would respect their wishes if they wanted to stay in their bedrooms. This was recorded in the care plans. People told us about some of the activities such as bingo and board games sessions. One person said, "We can go out when we want to. This is a sea-side resort so there is plenty going on." Another person said, "Staff respect I like to read. I read anything, books, magazines and newspapers. Staff are good at supplying me with material." Two people were able to tell us about a forth coming reminiscence session due to take place in October 2015. They said the person had been before and they had enjoyed the session. One person said, "It gets us thinking about the old days and how we've moved on. It's good. They come regularly"

People in their rooms all day were watching the television; some had visitors for part of the day and some were reading magazines or newspapers. Staff interacted with people in their bedrooms and were observed sitting, holding hands and talking to people.

There was an activities planner on display, which gave details of forth coming events. There were lots of pictures of events which had taken place inside and outside the home. These included cake making and visits out. The care plans stated the type of interests people had been interested in prior to admission. People's wishes to not participate in activities was recorded. However, there were no records of when staff had asked about individual interests and hobbies of people. So we did not know if people wanted to participate in other events. This was discussed with the manager. They stated it had been hard to identify individual hobbies of interest for people as they were more progressively suffering from ill health. This was an area under discussion at recent team meetings.

People told us their pastoral needs were cared for once a month. This included a monthly communion service and visits by local church members. One person said, "I like to attend my Holy Communion services and staff ensure I get to them." Staff were aware who to contact in the community if people had beliefs and faiths with which they were not familiar.

The people told us they would like to go out more but realised this was limited due to transport difficulties. Staff told us they often visited local events in the town and the shopping centre. This was recorded in people's care notes.

Staff were observed during the day helping people to participate in different activities and housekeeping tasks.

Good

Is the service responsive?

One person liked to help collect the dishes at meal times. Staff were observed helping people to read the newspaper and having a discussion about news topics. People were joining in the debates on the local news stories.

People with memory loss were reminded throughout the day about the times of day and where they lived. The signage in the home was in words and pictures to aid people moving about. However, there were no specific activities to help those people with memory loss to cope each day. This could prevent them from reaching their full potential.

People told us they were happy to make a complaint if necessary and felt their views would be respected. No-one we spoke with had made a formal complaint since their admission. People knew all the staff names and told us they felt any complaint would be thoroughly investigated. We saw the complaints procedure on display. However, there was no information about outside agencies that could help a person if they were not satisfied with an internal enquiry. The manager informed us they had contact with an organisation which could translate the procedure in different languages.

The complaints log detailed one formal complaint the manager had dealt with since our last visit. It recorded the details of the investigation and the outcomes for the complainant. Lessons learnt from the case had been passed to staff at their meetings. Staff confirmed these messages had been passed on. We saw this in the minutes of staff meetings in August 2015.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in post. This had been vacant since May 2014. The manager employed by the provider had recently submitted an application to CQC to become registered. They were awaiting an interview.

People told us they were well looked after, could express their views to the manager and felt their opinions were valued in the running of the home. One person said, "The manager is always here." A relative said, "I have no fears about expressing myself and giving an opinion. However, the manager and staff are approachable, friendly and helpful."

People who lived at the home and relatives completed feedback forms about the quality of service being received. These were issued throughout the year on an individual basis. Some people told us they had recently completed their forms. One person said, "It was simple to complete." We saw the results of 18 of the feedback forms from December 2014 to June 2015. The results were positive. However, there was no evidence of how the provider had considered the suggestions. People had suggested, for example, changes to the outside seating, more entertainers and regular contact with distant relatives.

Staff told us they worked well as a team. One staff member said, "I just love my job here." Another staff member said, "It's more like a home environment and people have told me that's what they feel as well." Staff said they could approach the manager about any issues of concern and they were approachable and friendly, as was the provider when they visited. Staff had received a questionnaire in May 2015. There were no negative comments made.

Staff told us staff meetings were held every three to four months. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of staff meetings for August 2015. The meeting had a variety of topics which staff had discussed, such as, infection control and caseloads. This ensured staff were kept up to date with events. The manager kept record books of when she had spoken with staff on certain topics which was pertinent to their department. This ensured the correct messages were received by the relevant departments.

There was evidence to show the home manager had completed audits to test the quality of the service. These were monthly and covered areas such as mattress audits, care plan reviews and call bell audits. However, there had been no analysis of those audits, even when actions were required. Such as, when call bells were out of action and when they had been repaired and when new bins were required for waste disposal. There was no method in place to ensure comments from people who used the service, relatives and staff had been taken into consideration as part of the audit process.

We were given a copy of the medicines audit which was in place. This had been completed in July 2015. Staff had not signed to say when they had completed any actions. We did not know whether staff had accepted the advice about good practice methods suggested in the audit. The medicines policy had not been reviewed since April 2009, but the manager told us she was seeking advice from their pharmacy supplier at the visit we saw was booked for the following week.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the 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 legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The implementation of the Mental Capacity Act 2005 was not being adhered to.