

Alder Meadow Limited

# Brookdale Nursing Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Good</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Requires Improvement</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

An unannounced comprehensive inspection visit took place on 18 December 2018 and we returned on 19 December 2018 to speak with staff and to review their quality assurance systems.

Brookdale Nursing Home is registered to provide personal care to older people including people living with dementia. Brookdale Nursing Home is a nursing home, which provides care for up to 40 people across two floors. At the time of our inspection there were 31 people living at Brookdale Nursing Home. People had their own bedroom and not all the bedrooms had en-suite facilities and four bedrooms were for shared occupancy. People had the use of shared communal lounges, dining rooms and bathrooms on each floor. To aid people's movement around the home, a passenger lift and stairs helped people move between floors.

People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we rated the service Good overall. Prior to and immediately following this inspection visit, we received information raising concerns about continence care, infection control and limited opportunities for people to pursue their interests. We looked at these concerns at this inspection and we found standards in how people were cared for had not been consistently maintained. In Well Led, people and staff told us changes to the feel and culture of the home had changed and although some improvements were noted, these needed to be embedded further to determine if they improved people's care and welfare. Overall, the rating has now changed to Requires Improvement.

The service did not have a registered manager, although a manager was appointed at the home in September 2018 and was in the process of applying for registration with us. 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.

Not all staff were positive about the changes in management, however staff agreed the changes being implemented by the manager were to improve people's experiences and care outcomes.

Staffing levels helped ensure people received the consistent care they needed, although staff said the use of agency staff meant the shift did not always operate effectively. The regional manager was confident staff levels were right and said staff needed to be deployed and managed more closely to improve the delivery of care. Staff did not always have time to sit and spend time getting to know people more. Our observations during this visit, were of positive and friendly interactions between staff and people but they were limited.

Staff did not always treat people with dignity and respect. Relatives and staff told us people wore other

people's clothes and the laundry system was not effectively managed to ensure people's own laundry items were returned. People's clothing was transferred to other areas of the home in black bin bags which showed no respect for people's personal property. Some people said staff entered their rooms without knocking which they did not appreciate.

Staff had a good understanding of abuse and the safeguarding procedures that should be followed to report abuse and incidents of concern. Risk assessments were in place to manage potential risks within people's lives, whilst also promoting their independence.

People's care plans provided information about the person's preferences and included some knowledge staff had gained about the person's interests and life history. Care records were reviewed and evaluated to ensure they remained up to date and changes made as required. However, some care plans we reviewed required more specific details to ensure staff provided consistent care. Staff had a hand over meeting held daily but some of the descriptions about people, were not always accurate. Staff said if people's needs changed, they were informed by way of a handover, however this needed to be more reflective of people's needs.

A process was in place which ensured people could raise any complaints or concerns. Concerns were acted upon and lessons were learned to reduce potential for similar complaints. The provider had systems to monitor the quality of the service. Actions were taken and improvements were being made, although some of the issues we found had not been identified. During and following our visit, the manager had taken action to make some improvements.

People were safe and satisfied with the support they received although most people said there was limited stimulation to keep them occupied. There were times people sat in different parts of the home with very little to do. The manager following their appointment, had begun to improve people's access to hobbies and interests.

Training records showed staff training was being completed and staff were equipped with the skills and knowledge to look after those in their care.

Staff worked within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff for the majority of time, sought people's consent before any care and support or choices were provided but there was inconsistency in staff practice.

People received support from nursing staff and other health care professionals. People were registered with a GP practice who visited people when needed. If people required other healthcare support in an emergency, staff were available 24 hours a day to seek that help or medical intervention.

People received their medicines safely by trained staff and regular checks on administration and storage ensured medicines were given safely and as prescribed.

There were examples of completed audits and checks that gave the provider confidence people received a safe, responsive and effective service. However, some of these audits were not accessible to us until following our visits because they were unable to be located, or IT problems meant they could not be accessed or shared. Significant changes in the management of the home and the staff team meant that changes needed to become embedded within the practice of the home. Changes with the manager and the care staff within the home becoming 'one team' needed more time to embed as some staff raised concerns with that poor communication and a lack of consistent teamwork impacted on the quality of care people

received.

Further information is in the detailed findings below.

## 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 remains Good.

### Is the service effective?

Good ●

The service remains Good.

### Is the service caring?

Requires Improvement ●

The service was not always caring.

People were not always treated with dignity and respect; their clothes were worn by other people and their clothing transferred in bin bags. The laundry system was not effectively managed to ensure people's clothes were returned to them, showing a disrespect to their personal property. Some people told us staff entered their personal room without knocking, which they did not appreciate.

### Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care records needed to be kept up to date when changes happened and they need to contain the right information for staff to provide consistent care. People had limited opportunities to do the things they wanted to do and some people sat in communal areas with limited stimulation. People's choices to receive their care in the way they wanted, were not always provided.

### Is the service well-led?

Requires Improvement ●

The service was not always well led.

The service had no registered manager which is a requirement of the provider's registration. Recent managerial changes had impacted on the management of the home and we got mixed feedback from people and relatives as to how positive those changes had been. Fire safety and health and safety checks were completed. The registered manager was committed to improving people's experiences at this home.

# Brookdale 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 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 unannounced comprehensive inspection visit took place on 18 December 2018. This visit was conducted by one inspector and an expert by experience. The expert by experience, had experience of caring for someone in this type of setting. The inspection team also included a CQC dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019. One inspector returned announced on 19 December 2018 to look at the provider's quality assurance processes.

Prior to this inspection visit and immediately following, we received information from people and staff suggesting staff were not always supporting people to meet their personal care needs and people's dignity was not always maintained. We looked at these concerns as part of this inspection visit and used them to help us form our judgements.

Prior to this inspection, we looked at information received from statutory notifications the provider had sent to us and from commissioners of the service. A statutory notification is information about important events which the provider is required to send us by law. Commissioners are representatives from the local authority who work to find appropriate care and support services, which are paid for by the local authority. We had not received any information of concern from the commissioners.

The previous registered manager had completed a Provider Information Return (PIR) before this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR during our visit. We found the information reflected how the service operated and provided us with a detailed, evidence based picture of their service.

During our inspection visit we spoke with three people living at Brookdale Nursing Home and three visiting relatives. Following this inspection, we received some information of concern from a member of the public, however we were unable to speak with them directly. We have considered their concerns in the preparation of our report. We spoke with the manager who was responsible for the day to day management of the service, the provider's regional manager, three nurses, four care staff, an activity co-ordinator and an external contractor who conducted fire and health and safety checks for the provider.

We reviewed three people's care plans, daily logs and medicines records to see how their support was planned and delivered. We reviewed records of quality assurance such as fire safety records, medicine audits, health and safety audits and organisational audits completed at provider level.

# Is the service safe?

## Our findings

At our last inspection, we rated this area as 'Good' because people felt safe living at Brookdale Nursing Home and they were supported by enough staff to meet their needs. At this inspection visit people continued to feel safe. Almost everyone told us, "I feel safe having people around."

Staff understood their role in keeping people safe and applied their knowledge in their working practice when people required support to reduce the risk of harm. Risk assessments included the safe number of staff and what they needed to do, to manage risks, such as when using specific equipment. Staff's knowledge of managing risks to those in their care, was in line with people's records. Risks to people using pressure relieving equipment were reduced because staff checked pressure relief settings remained accurate to each person.

Staff continued to protect people from abuse and poor practice because they knew the actions they should take if they had any concerns about people's welfare or safety. Staff told us any safeguarding issues would be reported to the management team or the provider. The manager knew what their responsibilities were to report and investigate poor practice.

Overall, people said there were enough staff to meet their individual needs. People said staff knew what help and support they needed, and if they could not support them immediately which some people told us, staff told them they would return to help as soon as possible. One person said, "Sometimes staff are about but sometimes you have to wait - but not a problem." Some people said they were not always able to have a bath when they wanted because of staff's availability.

Staff said there were enough staff to provide the care and support people needed, when they worked to assessed staffing levels. Staff said some shifts ran more effectively when they had their own staff and not agency staff, and staff who were experienced. However, they also told us some practices in the deployment of staff could make it more difficult to meet people's needs. For example, staff told us they were sometimes asked to go into the kitchen to prepare supper which meant it was more difficult to ensure people were supported when they needed it. The manager and regional manager were confident staffing levels were right because they had assessed people's dependency levels and provided more staff hours than had been assessed. The regional manager felt shifts may not run efficiently because of the deployment and management of staff, rather than a lack of staff. They told us agency staff were being used whilst they recruited, but they tried to use the same agency staff where possible. We were told of some agency staff who were no longer used because they did not support the values of the home. Staff said the reliance on agency staff limited the opportunities for them to work more as a team. The manager said they had flexibility to increase staffing levels if needed, so they could ensure there were sufficient staff to continue to support people's needs.

People raised no concerns to us regarding the administration of their medicines and said they received them regularly from staff when required. Daily checks were made to ensure medicines were given and medicines were stored within safe temperature ranges. In one example, we saw staff had not recorded a



date of opening on a topical cream which had a limited shelf life once opened. The nurse agreed to investigate this to ensure the cream remained fit for use. Time critical medicines were prioritised to ensure medicines were given safely and at regular time intervals.

The manager ensured regular fire tests were completed at the necessary intervals. Records showed fire tests, fire drills and emergency lighting were checked to ensure staff knew what to do and fire equipment was fit for use. People who used the service had up to date Personal Emergency Evacuation Plans (PEEPs). PEEPs are for people requiring special provision to ensure staff and the emergency services know what assistance they need to evacuate safely in the event of an emergency.

Prior to this visit, we received information suggesting poor infection control. During our first visit, we saw a staff member moved soiled nightwear in their hands and without the appropriate infection control measures in place, such as gloves and red linen bags. Other staff identified the poor practice and prevented further risk of cross infection by asking the staff member to immediately return to the room whilst they collected the appropriate bag. Staff felt this example of poor practice could be because certain personal care items and personal protective equipment was not always to hand and staff had to go and look for it which caused potential delays. Communal toilets and bathrooms contained hand gel, soap and paper towels to help minimise the risk of cross infection. Cleaning staff ensured the home remained as clean as possible and plans were in place to refurbish and renew the décor throughout the home.

## Is the service effective?

### Our findings

At our last inspection, we rated this area as 'Good' because people told us staff knew how to support them effectively. At this inspection we found staff continued to know how to meet people's needs and most people continued to be involved in their care decisions and daily choices. Therefore, overall, the rating continued to be Good, but we made some recommendations to the manager to ensure everyone received the same quality of choice and service.

Staff continued to receive training and refresher training to keep their skills, knowledge and practice updated, although a recent influx of new staff, meant not all staff had completed their training with this provider. Because some staff were completing their training, it was too early to fully assess if they put their training into practice. The manager maintained a training schedule to ensure staff training was regularly updated. Staff said they used their training in every day practice, such as moving people with specialist equipment and the right number of staff to ensure this was done safely and effectively. Where staff used a sling to help transfer people, each person had a sling in the correct size appropriate to them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Some people had authorised DoLS and these were followed by staff and reapplied for when required.

Staff understood the principles of the MCA for their practice. Examples were seen that showed mental capacity assessments in relation to decisions about the administration of medicines, personal care and the use of bed rails had been considered. Staff were able to explain why the measures were needed and why they were the least restrictive option. Consent was sought before most care and support was provided and records showed people had signed to give their consent for some processes and procedures. However, we saw some choices for people, such as meals, where they wanted to sit and what they wanted to do, was not always given. We discussed this with the manager about this who was not aware. The manager agreed to remind staff of the importance of providing people with choice at all times.

People had their main meal at lunch time. Two choices were provided and people who had specialist diets such as soft, pureed or vegetarian, had their needs met and their choices respected. People said the food was 'okay'. Comments included, "Food is okay, they will offer something else if they have it, if you don't like the choices, but it is sandwiches most of the time", "Portions are so so, never offered seconds" and "Always sandwiches at tea time and I don't like bread, occasionally we have omelette or poached eggs on toast." Almost everyone said the choices were the same and the menu was limited. The regional manager assured

us people had been involved in menu planning and more choices were being considered to give people variety.

People had access to other healthcare organisations. Typical comments were, "I had my eyes tested a few weeks ago and the chiropodist visits." A GP surgery completed regular visits and other health professionals such as district nurses, speech and language therapist and a dietician supported people's care needs. Some people had regular check ups with opticians, chiropodists and dental checks.

Plans to improve the environment and décor were in place. The home layout presented some challenges for people given the different levels and floors and this made it difficult for staff to have 'eyes and ears' across all areas of the home. For some people with a cognitive impairment, there was a lack of signage around the home, or cues to help people identify communal areas. Most bedrooms were numbered and had people's name on the door to help them identify their own bedroom.

## Is the service caring?

### Our findings

At our last inspection, we rated this area as 'Good' because people received a service from staff that were patient, considerate of people's needs and choices and kind in their interactions with people. However, at this inspection we found some people's dignity, respect and choices were not always sought or followed by staff. Therefore, the rating has now changed to Requires Improvement.

People were complimentary about the staff and the management's approach to them. Comments included, "Alright, good to me, happy here and staff are friendly" and "Carers (staff) are really nice." A relative was also pleased, saying, "The staff...very very good" and complimented staff on their patience. On both inspection visits we saw some staff interactions with people were kind and patient. When people needed reassurance and encouragement, it was given by staff. People's facial expressions and responses indicated they were at ease with staff. Staff were kind, patient and respectful when talking with people, addressing people by their preferred names and putting themselves on each person's level to make conversation easier. People said when personal care was provided, they were not rushed and felt comfortable. Staff understood how to protect people's dignity when personal care was provided.

However, a caring approach was not always felt by other people. For example, most people said when it came to respecting their privacy and dignity, they were less satisfied. A comment from most people was, "Staff don't knock... just open the door." We saw this during our visits. One relative said about respecting their family member, "It depends on which staff." At lunchtime on the ground floor, we saw people were not given a choice of where to sit and eat their meal. There was only one dining table and two dining chairs, so staff only took two people to sit at the table, even though four people had been asked and said they would like to sit at the table. Staff told us the other people wanted to sit in the lounge chairs and use a table brought up to them, but this was not accurate. One staff member said they could not accommodate everybody's wishes because the passenger lift could not take people up to the first floor and the dining area. However, when we checked the lift, it was fully functional. Communication about the recent lift maintenance was not fully understood by some staff, which impacted on people's choices.

Relatives, people and staff told us the laundry situation had become so mismanaged, people wore other people's clothing and it had become accepted practice. We saw two large black bags and a box full of 'lost property clothing'. The housekeeper said, these items had no labels 'so what can we do'. Laundered items were taken from the laundry room to the ironing room in black bin bags. This was not respectful of people's personal items. We asked staff if this was respectful and they responded, 'we don't have any other bags'. We discussed this with the manager, who purchased more suitable bags to move people's clothing through the home.

In the nurse station on the first floor, we saw a top set of dentures in full view. Staff told us they did not know whose they were and no one took responsibility to find out, or move them. We raised this with the manager who agreed that this was not a caring and respectful approach to people's care. They resolved the issue quickly and returned the dentures to their owner.

People's important, personal and confidential information was not always protected. Written care plans were stored securely in the nurse's office but staff accessed people's electronic care records on hand held devices. The security for these devices was not considered, so if a staff member left the device unattended once they had logged on, there was potential for unauthorised access if a device was misplaced, lost or stolen. We discussed this with the manager who put additional security measures in place to limit unauthorised access.

The environment presented challenges with the storing of equipment such as lifting hoists. Walking around the home early morning, we saw four hoists left in a first floor communal bathroom. The manager said this should not have happened as they should be left in people's bedrooms. We discussed this with the manager and recommended a more suitable location, other than a person's own bedroom. We felt this was not caring or a dignified approach to storage. There were rooms currently not occupied which would provided a short term solution and plans were being considered, to decommission rooms to offer more storage alternatives.

People's independence continued to be promoted and staff encouraged people to do as much for themselves as possible. Family members were involved in care decisions where needed. Relatives told us if there was a change in their family member's condition, they were kept informed which they appreciated. Relatives and a visitor felt welcomed into the home and had unrestricted visiting times.

## Is the service responsive?

### Our findings

At our last inspection we rated this area as 'Good' because people received a service that was responsive to their needs and continued to promote their social inclusion. At this inspection we found the service was not always responsive in meeting people's needs. In some cases, people had limited involvement in pursuing their own interests and if people felt anxious, staff were not always responding as quickly as people wanted.

Staff were not always responsive to people's social and emotional needs. People were not always offered choice and we saw some people left alone in communal lounges. One person was visibly upset which may have been due to how they were feeling, rather than being left alone. Staff were not always around to offer comfort. People told us they felt they were not included. People's comments included, "They don't ask what I would like to do" and "Staff don't ask about likes and dislikes." One person said they would like time to sit and talk with staff but, "Staff don't sit down and ask how I like things." One person said they wanted to speak with a family member on the telephone because they enjoyed this, but they told us staff never helped them to ensure this happened.

Other people found daily choices and how they lived their lives were not always responsive to their own preferences. For example, people could not always eat where they wanted to and people's preferred routines were not always followed. One staff member told us a person had not got up by 11.30am when their preferred time was around 08.00am. People's comments included, "I don't get up at the time I want, I have to wait as they are busy" and "I would love to have a bath, staff say okay and it never happens." On the first day of our inspection, one person was uncomfortable because they felt they were not dressed correctly and in accordance with their preferences. This person became increasingly anxious, but the staff member did not respond to their anxiety and take them to their room to make them more comfortable. Comments made by the person indicated they did not feel valued because their concerns had not been taken seriously.

Records to inform staff and staff's knowledge of people, was not consistent and did not always support the Accessible Information Standard (by inspecting this standard, we can help improve the quality of care for people who have an information and communication need related to a disability, sensory loss or impairment). For example, one person's paper and electronic care records stated they were blind. This was also recorded on a daily handover sheet that provided staff, especially new and agency staff, with a snapshot of the person's health and support needs. However, staff we spoke with told us the person was not blind and one staff member raised concerns about the effectiveness of the handover. Due to the conflict between the person's care records and staff knowledge of the person, we asked the manager to check the level of the person's visual impairment. The manager later confirmed the person was not blind and the records had been corrected to accurately reflect how this person's visual needs were to be met. Reviews and evaluations were completed but we could not see evidence of people's involvement in how they wanted their care delivered. The manager assured us care plans were now being improved and there were plans to include and involve people and family members.

There was some information in people's care plans about their wishes for end of life care. For example, care records recorded whether people wanted treatment in the event of a cardiac arrest. No one at the time of

our visit was receiving end of life care. The manager said this was a home for life and staff worked alongside other health professionals to ensure the right medicines and treatment were available when needed to ensure a pain free and dignified death.

People and relatives expressed disappointment with the level of activities in the home and during our visits, we saw people were left for periods of time, with limited stimulation or activities to interest them and keep them occupied. Most people said they watched television because staff were completing tasks so had little time to spend and chat with them. However, on the second day we were told an extra staff member had come in and we saw staff in conversation with people. Another person told us they felt occupied because they enjoyed knitting and reading which they did. Three people told us they would like to go out on trips but this was rare. Two people said they wanted to go in the garden but only went out twice in the summer.

The manager recognised the importance of meeting people's social needs and planned to increase meaningful activities for people. On our first visit, people and families had a Christmas party and a relative told us, "Since the new manager has been in post more activities were taking place with entertainers coming in and exercise sessions."

People knew how to complain and what to do, if they were unhappy. The manager told us about one complaint that was being responded to by the provider. We spoke with a relative who had raised concerns and although they had not yet received a response, they could see some improvements in the service.

## Is the service well-led?

### Our findings

At the previous inspection we rated this area as 'Good' because a programme of audits and continuous feedback from people helped ensure the service met people's expected needs. At this inspection we found improvements were needed. Therefore, the rating has now changed to Requires Improvement.

There was no registered manager in post. The new manager joined this home in September 2018 and was a registered manager in one of the provider's other homes. The manager told us since their appointment at this home, 19 staff left. They said those staff did not or were not prepared to work with them to work in a way the manager wanted. The manager said the registered manager had been at the home for over 20 years and staff got used to doing things their way. Having new staff in place, meant the staff team were still forming and getting to know each other's strengths, as well as those people they supported. Agency staff continued to support existing staff which meant the team was not yet formed to provide the consistency of care and knowledge, the manager expected. One staff member shared a concern that there was a lack of confidence some of the staff team would take ownership to do something, such as an activity.

Some staff said this affected the quality of communication and certain messages had not been communicated consistently, for example the lift being safe to transfer people. The manager agreed communication could be improved, especially in light of some of the issues we brought to their attention. In some cases, staff were told certain messages but there was limited or no follow up to ensure the message was put into consistent practice. Some staff said shifts worked better with those they knew and could trust. Some staff said the new manager's style was different and they did not respond well to how some messages were delivered to them. Some staff were not convinced changes were positive but they acknowledged this was could be short-term. All staff wanted things to improve because they wanted to provide people with the best quality of care they could.

A lack of oversight from nursing staff meant some clinical and other checks such as record quality were not completed in time, or followed consistently. One person was assessed as requiring four hourly repositioning to reduce the risk of skin breakdown. Staff records were incomplete and unable to demonstrate the support provided. Repositioning records showed the person was not repositioned at consistent intervals, plus, staff had not recorded how they had re-positioned the person such as on their right side, left side or their back. This had potential to put this person at unnecessary risk as staff maybe unaware of the persons next positional change. As written in this report, we saw some staff practice especially around privacy, dignity and respect that with close monitoring, could be avoided. The manager said the nurse was responsible for managing the shift. We spoke with nursing staff and it was clear they had limited oversight because they were dealing with other issues such as medicines, the GP, nursing care and care plan reviews. In one example, we saw documentation for a seizure was not completed until four hours later and another nurse said with distractions, medicines round sometimes took too long. To help alleviate this pressure, the manager and regional manager were considering a team leader position to manage the shift more effectively.

The manager had identified some, but not all, of the issues we found such as a lack of safe storage space,



poor laundry management, limited activities and some staff practice not respecting people's choice. We also shared some feedback to the manager around communication based on what we had identified that also limited some people's choice and freedom of movement. The manager agreed this needed to be improved and assured us they would make sure all staff were clear on what was required in terms of their role. Regarding space, the provider was looking to decommission rooms to free up more space for storage of hoist equipment instead of leaving it in bathrooms or people's bedrooms.

The regional manager said the change in management had changed how things were previously done and time was needed for the team to adjust. Of the new manager, they said, "Staff are engaging better and the new manager is engaging more with the church, improving activities and relationships with families." The regional manager accepted the culture had changed, but was confident it was for the better.

During the visit, we looked at audit records that were available for us to review. Some of the audits we saw fed into clinical audits so the manager had information to show how people's health conditions were being managed. Some audits, especially recent provider checks were not available for us to see, and no explanation was given as to why not. However, the regional manager told us they had been completed because head office staff had seen them. The provider completed other checks on health and safety, infection control and fire safety. These audits were completed regularly in line with the organisations expectations. These, plus water quality and utility checks ensured people were kept safe within the environment.

Providers are legally required to display the ratings we give them, within the home and on their website, within 21 days of receiving our final inspection report. We saw the provider had met their legal responsibility to display their latest rating in the home. The provider submitted statutory notifications to inform us of events that happened at the home in line with the legal responsibility.