Wellburn Care Homes Limited

St Georges 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 12 and 14 January 2016 and was unannounced. We last inspected St Georges Nursing Home on 22 January 2014 and found it was meeting all legal requirements we inspected against.

St Georges Nursing Home is a care home without nursing and provides accommodation and support for up to 38 people. Since the last inspection the service is no longer providing nursing care but it retains the name St Georges Nursing Home. Of the 38 single bedrooms, 24 had en-suite facilities and there were several accessible toilets and bathrooms on each of the two floors. At the time of the inspection there were 31 people using the service, some of whom were living with dementia.

The service had a registered manager who had been in post since September 2015 and who has been registered with the Commission since December 2015.
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.

Care plans were in place and evaluated on a monthly basis. Changes in people's needs which had been identified in the evaluations were not always updated in care plans so people may not have been receiving care that met their needs. Care plans did not always contain specific guidance for staff to follow, such as how to use the hoist when supporting a person with mobility needs. Detailed guidance on how to support people who were disoriented, distressed or confused was not always evident.

The registered manager was aware that care plans needed to be improved and this had been recognised in an action plan but there was no timeframe for completion. This meant there was an ongoing risk that people may receive inconsistent or inappropriate care.

Staff knew how to safeguard people from harm and abuse and how to report any concerns. They were confident that the registered manager would take action as required.

Accidents and incidents were recorded and action taken to minimise risks. Risk assessments were completed on a monthly basis and identified control measures to manage situations.

Risk assessments and contingency plans were in place in relation to the premises. Health and safety checks were completed and service contracts and maintenance plans were in place.

The registered manager had recently recruited a deputy manager and was waiting for pre-employment checks to be completed. These included references and a Disclosure and Barring Service check so they could be confident the person was suitable for the post. There were enough staff to meet people's needs but recruitment was ongoing for additional care staff.

Medicines were stored, administered and managed in a safe way. The staff who were responsible for administering medicines were trained and completed a competency check on a six monthly basis.

Other training included mental capacity, safeguarding, dignity, dementia and person centred care. Staff champions were being identified so they could receive additional training and act as a point of contact for any queries. Training was discussed in each staff member's supervision and in the team meetings. Staff said they felt well supported and well trained.

Authorised Deprivation of Liberty Safeguards were in place, and the registered manager and staff understood mental capacity principles. Staff included people in decision making at every opportunity.

People had access to health care services, with one relative saying, "They are very responsive to people's health needs." Where required people had been referred to the falls team and speech and language therapist, as well as having regular appointments for medicines reviews and sight check-ups.

People told us, "The food is lovely." Staff were knowledgeable about people's dietary requirements and ensured people were well supported. If people declined support with meals staff respected their wishes but remained observant in case the person changed their mind or was seen to be struggling.

Staff engaged with people in a warm and compassionate way, asking their permission and explaining what they were doing. Staff took time to answer people's questions and did not rush them in any way. Staff were respectful and treated people with dignity. One staff member said, "I treat people how I would want to be treated."

Activities were varied and, where possible, family members were invited to join in with bingo evenings and themed events such as pub lunches. The home was involved with the church next door and people could attend services at the church as well as services being held in the home. There were links with the local schools and amateur dramatics groups.

Staff were proactive in ensuring people maintained contact with family members and one person had recently used Skype to see and talk with their family who lived in Australia.

The registered manager had been in post since September 2015 and relatives and staff were very positive about the impact they were having on the service. Comments included, "The best manager I've had," "They've made some really positive changes," "They are always on the floor and know people really well."

A range of audits were in place and there was a culture of working together to drive improvement.

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 and their relatives told us they felt safe and well looked after.

Risk assessments and contingency plans were in place.

Accidents, incidents and safeguarding concerns were recorded and acted on.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were trained and said they felt well supported by the registered manager.

Mental capacity was understood by staff and there were appropriate authorised Deprivation of Liberty Safeguards (DoLS) in place.

People told us the food was good and people's dietary needs were catered for.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were very well cared for.

Staff approach was respectful, warm and compassionate.

People were involved and their decisions were respected by staff which supported people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always identify triggers or strategies to support people safely.

Evaluations of care happened on a monthly basis and changes were identified but this did not always lead to a new care plan being written,

There were a range of activities available for people and their families.

People and their relatives said they knew how to complain but they had no concerns.

Is the service well-led?

Good

The service was well-led.

There was a strong ethos of continuous improvement which was shared by the whole team.

Relatives told us the registered manager and the team "Are brilliant."

An action plan was in place to drive forward improvements and regular audits identified areas for development which were actioned.

St Georges 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 inspection took place on 12 and 14 January 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up on one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also 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 what improvements they plan to make.

We also contacted the local authority commissioning team and the safeguarding adult's team as well as the local Healthwatch who did not raise any concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with three people living at the service and four relatives. We also spoke with the registered manager, the activities co-ordinator, a team leader and three care staff.

We reviewed three people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

One relative said, "I have no concerns, my [family member] is very safe." They added, "We were very pleased to get them in here." One person said, "I feel very safe here, I'm well looked after." Another said, "I'm very settled and well looked after, I'm perfectly safe."

Staff understood how to safeguard people from harm and abuse. One staff member said, "I would report it to the manager, the area manager, the team leader. I'd keep going until action was taken but the manager would definitely act." They went on to say, "Safeguarding information is available in the staff room and in the office, we are all trained as well."

Guidance was available for staff on what safeguarding means and how to make an alert; it also detailed what staff should and shouldn't do if someone disclosed abuse to them. Where concerns had been raised there was information recorded on the action taken.

Risk assessments were completed on a monthly basis in relation to moving and handling, falls and other identified risks. Assessments were made of people's walking; the support they needed with personal care; overnight care; and transferring from bed to chair and so forth. Control measures included ensuring one person used a high back chair which was at the correct height for them and in good condition. Risk assessments included information on the numbers of staff needed to support the person and the equipment they needed to use.

Staff were able to describe the procedure they would follow in emergencies, such as a fire alarm. One staff member said, "We check doors with the back of our hands and move people two fire doors away from the fire. If we needed to move people downstairs we know how to use the evacuation chair and the fire mat." Simulated fire drills were completed regularly and staff role-played the part of people using the service.

Each person had a personal emergency evacuation plan which detailed where their room was in the building and how staff should safely evacuate the person, including any equipment that would be needed and if two staff were required.

All necessary building and health and safety certificates were in place such as gas safety, portable appliance testing, lifting equipment and legionella checks. Regular health and safety checks were completed and any defects were noted, recorded and action taken. A range of health and safety risk assessments were completed and regularly reviewed, including manual handling, fire safety, use of electrical equipment and extreme weather conditions.

A business continuity file was in place and reviewed six monthly to ensure staff had procedures to follow in the event of fire, flood and loss of utilities.

Accidents and incidents were recorded using an accident book. Incidents were investigated and trends reviewed and any necessary action was documented and recorded. Accidents were analysed on a monthly

basis and action taken included referrals to falls team and the use of sensor mats and observations. The registered manager had identified that two staff had volunteered to take a lead role in relation to falls and was in the process of identifying training and setting up regular meetings to discuss actions and monitoring.

People felt there were enough staff to support them. One relative said, "Oh yes, there's enough staff to care for [family member]." Another said, "My [relative] has never complained of having to wait for anything so I would say there's enough staff." A staff member said, "Yes, there's enough staff, we don't need to rush anything."

The registered manager explained that they had recently appointed a deputy manager and were waiting for confirmation of their Disclosure and Barring Service check (DBS) before they started. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. They said there were enough staff but it was very busy so they were recruiting a new care worker. Agency staff were rarely used and if they were they received an induction to the building and always worked as a second person with a competent staff member.

The recruitment procedure included a standard application form and interview before anyone was offered a post. A DBS check was completed and two written references were sought, one of which was from the most recent employer. All references were verified by telephone calls to the referee.

A medicines dispensing system was used which meant that each person's medicines were sealed in a blister pack by the pharmacy so they could be administered at the required time, with the required dosage. Each person had a medicine administration record (MAR) which staff dotted when they checked the medicines and then signed after people had taken their medicine. Each person's photograph was with their MAR together with any special instructions on how they liked to take their medicines. Copies of people's care plans were available on the medicines trolley so staff could refer to them as needed.

Some people's care plans and MARs stated that their medicine should be crushed. A staff member said, "We have written permission from the GP before we do this." This information was available within people's care records.

A colour coding system was used for administrations at specific times of day and staff used a coding system to identify if people were in hospital or if they had refused medicine. One staff member said, "If someone kept refusing their medicines we'd record it all and return it in the refusal book. If they missed several we would speak to the GP to see if they could have it in a liquid or some other format and we'd keep reviewing it."

A team leader administering medicines confirmed that they had completed safe administration of medicines training as well as having their competency assessed every 6 months. The registered manager said, "Care staff complete a DVD session on medicines in case they are countersigning for controlled medicines." Controlled medicines have stricter legal controls to prevent them being misused or causing harm.

All medicines were ordered, administered, stored and recorded appropriately.

Good

Is the service effective?

Our findings

Staff felt well trained and competent to carry out their role. One staff member said, "There's always training going on, we are asked about it in our one to one (supervision). I've done lots of training, I really enjoy it."

All staff received regular training which included safeguarding and the prevention of adult abuse, medicines, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), dementia, principles of care, communication and person centred care. Training was discussed within supervisions and a matrix was in place which showed that training was up to date. The registered manager had arranged further training for staff in areas such as care planning and was developing a champion programme which meant some staff would have additional training in specific areas such as dementia.

The activities co-ordinator said, "I have my NVQ 2 and 3 in social care, and I'm doing a customer care diploma. Once I've done that I want to do an activities diploma." An induction programme was in place for new staff which met the requirements of the care certificate. The care certificate is an identified set of standard skills, knowledge and behaviours for care staff to provide compassionate, safe and high quality care and support.

Staff said they had regular supervision and felt well supported in their roles. Supervisions give staff the opportunity to meet with their manager on a regular basis to discuss their performance and competency. Supervision and appraisal records were kept in staff files. The registered manager said, "Supervisions were all done in November, so due in January. I plan to do all the appraisals in February and then supervisions again in March so we don't miss anyone."

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager explained that some people had authorised DoLS in place and that they had ongoing applications for other people. They explained that at the request of the local authority they were staggering requests in order to ensure they were dealt with in a timely manner. We saw that appropriate requests had been made and authorisations were in place.

One relative said, "Staff are really responsive with health needs, they know everyone and would do everything I would do as a daughter." Another said, "[Family member] is getting measured for a wheelchair so they can go out more, we are happy with everything."

District nurses visited regularly and each person had records of professional contacts and visits which included their doctor, chiropodist, dietitian, speech and language therapist (SALT), opticians and so forth.

One relative said, "There's nothing wrong with the food, its proper home-made food, there's always a good choice, it looks lovely." Another said, "The food is fabulous."

There was information available in the kitchen and dining areas for people who needed a soft diet. Staff serving meals were very knowledgeable of this and ensured everyone's meals were presented according to their individual needs.

People were offered juice and hot drinks regularly during meal times. In additional to hot drinks being served at regular intervals during the day there was constant access to fruit juices and water.

After lunch one person said, "That was very nice thank you," and helped to clear the dishes and cutlery away. Another person said, "That was tasty."

The registered manager was in the process of implementing the National Early Warning Score (NEWS) which would provide care staff with clinical guidance on seeking support from health care professionals and help to prevent illness from being undetected.

People had hospital passports which contained the things hospital staff must know about the person, the things the hospital staff need to know and the things they should know. The registered manager explained they were working with the NHS and other registered managers to look at safe discharge from hospital. The hospital passport was being used as an example of best practice documentation within this framework.

Good

Is the service caring?

Our findings

One relative said, "Before [family member] moved here they wanted to be on their own all the time. They spend time in the day room now; they are settled and very happy." They went on to say, "The staff are lovely, they are kind with us as well. There's good communication and involvement, I can't fault them." Another relative said, "It's a dream come true that [family member's] here, it's good to get them somewhere good. Everything is lovely."

Another relative said, "The girl's do their best, communication is really good, they know [relative] well. I'm very happy with things."

One staff member said, "I love it here, I wouldn't do anything else." They went on to say, "I like meeting people and learning about their lives and their history, I like looking after them."

One relative told us, "We absolutely love it, [relative] is very settled, we are over the moon. There's lots of guilt moving a parent but they are absolutely fabulous here." They went on to say, "The manager is approachable, very hands on, he's here in the night, the staff are happy, they are all approachable. There's an open door policy and we can visit anytime. I'd be happy to move in myself!"

Staff treated people with kindness and compassion. People were spoken to using their preferred names or terms of endearment which were acceptable to people. Staff spoke with people and explained what was happening offering time and encouragement to complete the task, such as moving and assisting. One person asked staff questions whilst they were being supported and staff took the time to make sure they answered the questions fully and that the person understood.

If people were disoriented such as asking when their Mam was coming to take them home, staff responded by distracting people, for example by suggesting they stayed for lunch first. Staff spent time with people generally chatting or singing in order to reassure people.

People were asked where they wanted to sit for their lunch with some people choosing to sit in the lounge whilst others sat at the dining table. Some people read the menu out to other people having lunch whilst staff plated meals up and showed them to people so they could see what the choices were and make an active decision over what they wanted to eat. Staff observed one person's eye movement which indicated which meal they had chosen to have.

Staff also asked people how much they wanted to eat, and whether or not they would like gravy on their meal and where they would like it. Where staff were offering physical support at meal times with eating, they explained to people what they were going to be eating and asked if people were ready before offering food. Staff also offered drinks at regular intervals during the meal, in case people wanted a break from the meal and needed a drink of juice or tea.

One person who was dozing at the dining room table was gently wakened by staff stroking their hand and

saying their name in a quiet and calm manner. Throughout the meal staff spoke to this person in a gentle, supportive manner and encouraged them to eat their meal. If staff felt that people needed some support they asked if they could help before doing so and if people said no this was respected. People were not rushed to eat a meal, one staff member said, "If it takes three hours what does it matter as long as they are enjoying it."

A detailed brochure about the service called a service user guide was available for everyone and included information on the purpose of the home, the training of staff, the facilities and care offered, activities, quality assurance, complaints, advocacy, privacy, dignity, choice rights, and menu plans.

Requires Improvement

Is the service responsive?

Our findings

Care plans about each person's needs were in place and were evaluated on a monthly basis. Evaluation notes for some people included the recognition that their needs had changed however this did not always trigger an updated care plan. The registered manager had identified this as an area for improvement as care plans needed to be more person-centred and accessible; they should be easy to read and include more specific about how the person wishes to be cared for. The action plan was in place however there was no timeframe for updating the care plans.

People had mental health care plans and plans around communication and sensory needs. These included statements such as, '[Person] can be hard to understand when panicked and unsettled,' and 'can be confused and disoriented.' There was no information available on situations that may lead people to feel panic or confusion, nor were there strategies for staff to follow on how to reassure the person. This meant staff might respond in inconsistent ways which could confuse the person further.

We saw a medicine care plan which stated the person lacked capacity to understand why they were taking their medicine. We spoke to the registered manager about this as there was no capacity assessment in relation to medicines. The registered manager, said, "Yes, I understand what you mean, it hasn't been assessed."

Another person had a care plan for personal hygiene which stated they could be 'really stressed when assisted with personal care.' There was no explanation as to how the person expressed this, nor how staff should support the person whilst they were distressed.

A moving and handling care plan stated a person needed to use the hoist and be supported by two staff. It stated, 'correct equipment and follow manual handling procedure properly when transferring, correct equipment and sling to be used.' There was no information in the care plan about what specific equipment should be used nor how it should be used. This left the person and staff at potential risk of harm or injury if they were not following the correct procedure.

Some care plans detailed how people liked to be supported and the areas where people were independent and did not need support; others specified were people need a verbal prompt and encouragement only. All the information was recorded on one sheet with no headers to indicate if the information was the assessed need or the support the person required. This made it difficult to find the personalised information amongst all the other detail.

Reviews were held six to eight weeks after admission to the home however these were not consistently recorded.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said, "We have a meeting to discuss care plans, the area manager agrees the format isn't fit for purpose and there's work to be done. Documentation in general needs to be reviewed but care plans are the priority." They added, "I am trying to bring reviews for residents in line, for example so they happen each June and December, that way they won't get missed. I'm trying to do a monthly theme." They went on to say that care plan training was being delivered for staff as they had all done DVD training so this was being supported by some face to face training.

People and their relatives were complimentary of the care they received. One relative said, "My [relative] is happy; I've never seen anything but good support."

The activities coordinator said, "I keep a life story book in people's room, it's their family, childhood, work, significant people and places, likes and dislikes. It's then used in care planning." Care records also included information on people's life history and the key things to know about the person.

The registered manager had recently introduced a small shop which sold toiletries, cards and everyday items that people might need. Any profits from the shop were put into the residents' fund for activities and outings. The registered manager said, "Further improvements will be made to the activities programme with more focus on the community, to build better community links and prevent isolation." The activities coordinator said, "I want to do more specifically around dementia, I already do reminiscing and hand massage but I want to look more into it, I know I need to learn more."

One relative said, "There's always lots going on. Singers come in, a violinist; there are things on all the time. All credit to them, it's good that they have boards up so we can see what's going on and speak to [relative] about it."

The activities co-ordinator said, "The carers do a daily chat and I do something different, I do flower arranging, manicures, exercise classes come in, trips out, theatre and musicals, entertainers, we have theme nights one a month, bingo or a craft fair, bar meals with families, quiz nights, dominoes, the library visits. I'm going to get audio books for people." They added, "We try to get families involved as much as we can, but it's not always easy." They went on to say, "We work closely with the church next door. Some people go to the church and we have services here too with Communion for people." They explained how, at Christmas, they had opened their doors to any older person who was going to be on their own so they could spend Christmas Day with others and enjoy a Christmas dinner. They also explained that there were close relations with the local primary schools and amateur dramatics groups. They added they also supported one person to Skype their family who lived in Australia. This meant they could see their family and have a conversation with them at the same time.

One of the accessible shower rooms also doubled-up as a hairdresser and was well equipped to meet people's needs.

A complaints and compliments file was in place, there were many thank you cards in the file praising the care offered by staff. One complaint had been logged in relation to some maintenance in their [family member's] room. This had been dealt with and it was recorded that the family were satisfied with the action taken. People we spoke with and their relatives said they knew how to complain but had no concerns and had not needed to use the procedure.

Residents and relatives' meetings were held on a routine basis and included a 'homes update' where any refurbishment was discussed as well as recruitment, activities, menus and community involvement. One relative said, "We have regular resident and relatives' meetings. The contact and communication is good."

Good

Is the service well-led?

Our findings

During the inspection two failures to notify the Commission of incidents were found. This had occurred prior to the new manager being post and is being dealt with outside the inspection process.

One relative said, "[The registered manager] is lovely, he's always on the floor doing something!" Another relative said, "There's been a vast difference since [registered manager] took over, people are well looked after." They went on to say, "[Registered manager] will work on the floor and is part of things, they are brilliant. We love everyone, the staff are brilliant."

One staff member said, "[Registered manager] is one of the best managers, they really get stuck in. You can't tell staff how to look after people if you don't know yourself."

Another staff member said, "The manager listens, they are genuine and take on board what we say. They can be firm if needed but then that's the end of it. I want to do it for him, he's really turned this place around."

A range of audits were completed on a regular basis which assessed the environment and cleanliness of the home, as well as checks on records and documentation such as health and safety, care records, medicines, training, complaints, staff files and staff and resident meetings. Action plans were put in place where it had been identified that improvements needed to be made and once these were completed they had been signed off. This meant there were systems in place to monitor the service and identify improvements.

A dementia care audit had been completed and it had been identified that further action was needed in relation to activities for people living with dementia. This included sensory and tactile objects for people as well as engaging people in relation to their previous work and life experiences.

Care plan audits were being completed and assessed the quality of the information recorded as well as ensuring all necessary documents were in place. The registered manager said, "The care plans need more work to be more person centred, so we have a working group to look at them as they are quite clinical based." This had been identified on the service action plan, with initial steps to include training team leaders on care planning.

In addition to the registered manager's audits, a senior manager also completed a monthly audit, which assessed whether the service was safe, effective, caring, responsive and well led. The latest action plan included plans to improve care records.

The registered manager had a plan for developing the service which included the introduction of care champions who would attend additional training in specific areas and act as key points of support for the rest of the team. These roles had been discussed in team meetings and one staff member said, "I've asked to be a champion in dementia care, I know it's really complex and I want to learn more about it." The plan also included a dignity action plan. Staff surveys had recently been completed which included their view on all

areas of the home and how improvements could be made. The results of this were yet to be analysed but the registered manager said, "I will be producing an action plan based on the findings."

The registered manager had an open door policy and regularly worked alongside staff to monitor performance and ensure the service was effective. During our visit we saw the registered manager was supporting people and staff, for example, with mealtimes, medicine administration, and attending activities. They were very visible and this was remarked upon as being a positive improvement by everyone we spoke with.

One staff member said, "There's nothing I would change, we have come on a lot in the past months, the manager has made a huge difference and we are getting back to where we used to be. I work with some lovely people, staff, clients and families. It's all lovely, lovely, lovely."

The last team meeting had been held in October 2015 and included an update on the home, training, policies and procedures, safeguarding, care records and standards within the home. The registered manager said, "That will have been the last one, as we missed December's with Christmas. I plan to get on track and do them every two months."

A deputy manager had recently been appointed, although they were not yet in post. Their role would be to focus on supporting the registered manager with overseeing the home and monitoring of staff.

The registered manager said, "My role is very busy at present due to covering [for the deputy manager] but I knew that when I took the job on. It's my role to be out on the floor." They went on to say they felt fully supported by the area manager.

The registered manager had signed up to be part of the 'My Homelife' scheme which is a leadership support programme for care home managers. The programme aims to develop skills, engage managers in evidence-based relationship-centred practices and resolve complex everyday issues that impact upon the quality of services.

The registered manager also attended managers meetings within the organisation where managers could share ideas, discuss policies and best practice. They also had established links with the Tyne & Wear Care Alliance.

A range of policies and procedures were in place which detailed the date they were issued and when they were due for review. The registered manager had discussed introducing a policy of the month for the staff team to ensure they were up to date with procedures.

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 plans in respect of people using the service were not always complete or updated so there was a risk they may receive inconsistent or inappropriate care. 9(3)(b)