Touchstones Care Ltd

Touchstones

Inspection report

9-11 Shakespeare Road
Worthing
West Sussex
BN11 4AL

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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?	**Good**

Summary of findings

Overall summary

The inspection took place on 2 February 2016 and was unannounced.

Touchstones provides care and accommodation for up to 19 people and there were 18 people aged 35 to 80 years living at the home when we inspected. The service specialises in the care of adults with a mental health need.

The service had 11 single bedrooms and four doubles. There were two communal lounges and a conservatory as well as two kitchens, one of which people could use to prepare their own food and drinks between meals. The home had two shower rooms and two bathrooms; two of these also had a toilet. There were also four additional toilets.

The service did not have a registered manager and was being managed by the provider who had applied to the Commission for registration as manager. 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.

Whilst risks to people were assessed, and, there were care plans to mitigate those risks, we found two areas where greater detail was needed to show all relevant information had been considered.

The environment was in need of attention in certain areas and action had not been taken regarding risks from hot water, falls from first floor windows and from hot surfaces such as radiators.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

People received their medicines safely.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People at the service had capacity and the staff sought people's consent about arrangements for their care.

There was a choice of food and people were involved in planning the menus. People's nutritional needs were assessed so the right action could be taken if people were at risk of malnutrition.

Staff were skilled in working with people who had mental health needs although we identified staff training needed to be improved so staff had a more thorough knowledge base of specific illnesses.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff were caring and acknowledged people's privacy. People commented that staff were understanding of people's mental health needs and provided support during periods of distress. Staff had positive working relationships with people and offered informal counselling and listening to support people. The staff promoted people's independence.

Care was provided to people based on their individual needs which we call person centred care. People were fully involved in the assessment of their needs and in care planning to meet those needs. Staff had a good knowledge of people's changing needs and action was taken to review care needs.

Staff listened and acted on what people said and there were opportunities for people to contribute to how the service was organised. People knew how to raise any concerns.

The views of people, relatives and health and social professionals were sought as part a quality assurance process. The culture and ethos of the service was focussed on people being involved in the running of the service which in turn empowered people and helped build their confidence.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not always safe.

Risks and maintenance of the premises were in need of attention. Not all risks to people were fully considered and planned to ensure people were safe at all times.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained in a number of relevant areas and received regular supervision, but we also identified staff training in the care of people with specific conditions could be improved.

Staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards (DoLS). People's consent to the arrangements for their care was obtained.

People were supported to have a balanced and nutritious diet. Special dietary needs were catered for.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to people. Staff were understanding of

those with mental health needs.

People were consulted about their care and had opportunities to maintain and develop their independence. Staff acknowledged people's privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences. People were fully involved in the assessment of their needs and in devising their care plans.

People were supported to attend a range of activities including the use of community facilities.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people, staff, and stakeholder professionals regarding the quality of the service and to check if improvements needed to be made.

The culture of the service focussed on the needs and preferences of people who were involved in aspects of how the service ran.

There were a number of systems for checking and auditing the safety and quality of the service.

Touchstones

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 was unannounced and took place on 2 February 2016.

The inspection team consisted of one inspector and an Inspection Manager.

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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with eight people who lived at the home. We also spoke with four care staff and the provider.

We also spent time observing people in the communal living areas and observed a staff meeting.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a social worker for one of the people who lived at the home. This person gave their permission for their comments to be included in this report.

The service was last inspected on 17 October 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

We identified two aspects of risk where there was insufficient records to show these areas were fully assessed. For one care plan there was a risk assessment regarding mental health needs with an action plan of what staff should do to safely support the person, but this did not include a significant factor regarding risks to mental well-being and safety. This was discussed with the provider who said precautionary measures were taken to mitigate risks but did not include all risk factors. Another omission related to a lack of information, follow up and assessment. Risks to people had not been fully assessed and records made of action staff should take to minimise them. There was also a record of an injury one person sustained which was recorded on a body map chart without a date on. This meant the provider had not ensured all risks were assessed and reviewed in order that people were always safe.

Sufficient measures had not been taken regarding the assessment of the risk of falls from first floor windows, scalds from hot water and burns from radiators. The Health and Safety Executive publication 'Health and Safety in Care Homes' advises precautions and risk assessments regarding the prevention of burns from hot surfaces such as pipes and radiators, as well as the risks of falls from windows and scalds from hot water. We also found a number of areas of the premises were in need of repair. These included damage to ceilings from water leaks, a missing drawer in a kitchen unit, mildew on a bedroom ceiling, partially completed repairs surrounding a wash hand basin in a bedroom and a large hole in a bedroom carpet. A first floor shower room was also in need of attention as tiles were cracked, grouting was discoloured and there was excessive mildew; the manager explained this was already being addressed. There were no plans for addressing these decorative defects although there was maintenance checklist which did not include these items. The provider had not ensured the premises were fully safe. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the service and that they received safe care. For example, people told us how staff looked after them well and one person commented, "It's OK. We get looked after. We are really grateful for what they do for us. We do get looked after." People also described arrangements for going out in the community and how they told staff where they were going in case of any emergencies. People also said they would approach staff if they had any problems about their safety.

People told us there were enough staff on duty and that staff were approachable. For example, one person said, "There are enough staff and they always have time to talk to you."

The service had policies and procedures regarding the safeguarding of people, which included details about the definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was also a copy of the local authority safeguarding procedures as well as a notice board in the office so staff had details of who to report any safeguarding concerns to. Staff had received training in safeguarding procedures, had a good knowledge of what abuse was, knew what to do, and who to report any concerns to.

Risks to people were assessed and there were care plans for staff to follow so these risks were minimised.

People were involved in these assessments, which included going out in the community and for the management of mental health needs. For example, one person's care plan included details about how to handle emotional upset by techniques of distraction and spending time comforting the person. Records showed staff followed up areas of identified risk with relevant professionals or where an incident had occurred. Staff told us how risk assessments were regularly reviewed and how staff had a good knowledge of risks to people and how they should be managed. We saw how people were consulted about the risk assessments and were fully involved in discussions about how to manage risks. For example, one person told us, "If I'm going away for a night I have to tell them and we do a risk assessment."

Sufficient numbers of staff were provided to meet people's needs. People told us there were enough staff to meet their needs and we observed sufficient numbers of staff so people had access to staff when they needed. People were relatively independent and did not require assistance with any personal care or mobility needs. A staff duty rota was maintained which showed from Monday to Friday there were four staff on duty in the mornings and three staff in the evenings. On Saturdays and Sundays the duty rota showed two staff on duty. Staff confirmed these staffing levels were provided and said they considered there were enough staff to meet people's needs. For example, one staff member said how there was a good team spirit, that staff were always available as a back- up, and, that they were able to spend time talking with people. Night time staff consisted of one staff member on 'sleeping' duty who could alert other staff not in the building if this was needed. There was a lone working policy with guidance for staff on procedures regarding safety when working alone; staff were aware of these.

We looked at the staff recruitment procedures. Each staff member had completed an application form which included an employment history. There were records to show staff were interviewed to check their suitability for the post. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. We noted references for two staff were obtained after the staff member started work. This was discussed with the manager who said in these circumstances the staff would attend training only until the references were obtained. We also saw one staff member's DBS check was obtained a week after the staff member started work. This was also discussed with the manager. Whilst a DBS check for the staff member was obtained we stressed the importance of following the Registration under the Health and Social Care Act 2008 Disclosure and Barring Service (DBS) checks guidance that staff must only start work after not a DBS has been applied for and an Adults First check obtained after which the staff member must work in a supervised capacity until the DBS is returned.

We looked at the service's medicines procedures. The service had policies and procedures regarding the ordering, storage and handling of medicines. People said they were supported to take their medicines when they needed them. Staff were trained in the safe handling of medicines, which involved observation of staff competency to do this. People were supported with their medicines based on their own preferences and if they were assessed as able to safely administer their medicines themselves. Where staff supported people to take their medicines there was a record each time staff did this on a medicines administration record (MAR) to evidence that medicines were given as prescribed.

Where people had medicines on an 'as required' basis care plans included guidance for staff to follow to recognise the symptoms when this medicine was needed. However, there was no care plan for one person to say when a medicine prescribed should be taken on an 'as required basis.' There was also a recent error in the administration of this medicine, which the provider had looked into and followed up with the staff member; this underlined the importance of the right guidance for staff being recorded. The manager completed a care plan for this 'as required' medicine immediately following the inspection which was supplied to us.

People were supported with managing their diabetes, which involved staff checking people's blood sugar levels and then guiding the person to take the correct amount of insulin. We observed a staff member supporting a person to check their blood sugar levels. We also checked medicines records which showed insulin was administered in line with test results and guidelines. Procedures were recorded for how staff should carry out these procedures. People's individual records gave information on how hyperglycaemia and hypoglycaemia should be managed and when medical assistance was needed. There was a 'diabetes folder' for staff to refer to, which included information about diabetes.

Checks were made by suitably qualified persons of equipment such as the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. The service was inspected by the fire service in November 2015 and was found to be 'broadly compliant' but with some areas in need of attention, which the provider confirmed had been completed.

Requires Improvement

Is the service effective?

Our findings

People told us they were supported by staff who were skilled in working with people with mental health needs. For example, one person said how the staff knew their mental health needs were changeable, that they would go to staff when they did not feel well and that staff responded appropriately. Another person said of the staff, "Jolly fine, all of them. They got me stabilised." People said they discussed their care needs with an assigned staff member called a keyworker and had agreed to the type of support they needed.

Staff received training, supervision and appraisal of their work in order that they had the skills and knowledge to look after people well. There was training which the provider considered mandatory for all staff to attend, which included mental health awareness but only five of the 12 staff had completed this. Two staff had completed a training course in diabetes but this over two years ago. In view of the fact several people at the service had diabetes the absence of specific training in this meant staff may not have sufficient knowledge of the condition. There was no training for staff regarding the care of people who experienced specific conditions such as different mental health conditions such as Korsakoff's syndrome, other mental illnesses or substance misuse. The provider stated there were plans to extend training to cover these areas. A staff member also commented that training on mental health and substance misuse could be improved. Although we observed that staff understood people's individual histories and needs well, we recommend the provider expand the staff training programme to include training courses regarding specific health and mental health conditions experienced by people in order to ensure staff have up to date knowledge and skills about people's needs.

Newly appointed staff received an induction training programme to prepare for work at the service. The provider told us this was comprehensive and covered the aims, objectives and purpose of the service. There was an induction procedure called 'Introduction to Touchstones,' which included an induction checklist to confirm staff were instructed in lone working, the care of people and staff conduct amongst other areas. Staff confirmed they completed the induction 'Introduction to Touchstones,' and that the induction involved observation and assessment of their competency. Staff also said they worked in a supernumerary capacity so they could observe more experienced staff in order to learn the role. Staff also enrolled for the Care Certificate which is a nationally recognised induction process set out by Skills for Care.

The provider maintained a spreadsheet record of staff training in courses considered mandatory to provide effective care and when staff had completed these. This allowed the provider to monitor this training and to check when it needed to be updated. These courses included infection control, moving and handling, fire safety, first aid, mental health awareness and diet and nutrition.

The provider supported staff to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. The provider confirmed five of the 12 staff were trained to NVQ level 2, one to NVQ level 3 and one to level 5. The provider was qualified at NVQ level 4. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff told us the training they received was of a good standard and that the provider encouraged staff to attend training courses. Therefore staff were

supported to achieve further qualifications to enhance their skills and knowledge. Discussions with staff showed they were motivated to improve their skills and said how much they enjoyed their work with people.

Staff confirmed they received regular supervision which allowed staff and their line manager to discuss their work, training and future plans. Staff said they found the supervision sessions useful. Records of staff supervision and annual appraisals of their work were maintained and covered the care of people, training and updates on relevant legislation.

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). Staff were trained in the MCA and had also signed to acknowledge they had read and understood the service's MCA policy. Conversations with staff and people confirmed people were consulted and had agreed to their care, which was demonstrated in care plans which people had signed in agreement. None of the people at the service had been assessed as being unable to consent to their care and treatment. The provider described how any queries regarding people's capacity were discussed with the relevant social services staff.

People's nutritional needs were assessed and recorded on a nutritional risk assessment; these included a risk score indicating if further action was needed. A record of people's weight was also maintained so any weight loss or gain could be identified. Where weight loss was identified this was followed up with the person's GP which was recorded in the care records. Care plans included details where people needed to be monitored to ensure they ate enough. Nutritional assessments were repeated at intervals for those identified at risk of weight loss. The service did not use a malnutrition universal screening tool (MUST) which gives a body mass index and score regarding the risk of malnutrition, which is recognised by dieticians. This was discussed with the provider to consider using this tool in future.

There was menu plan for a four week cycle, which showed varied and nutritious meals. People said they were consulted about the meals and confirmed there was a choice. For example, one person said of the food, "It's OK. There's a choice and you can always have an alternative." Another person said, "The food is very good. There's a menu choice. Fresh fruit and vegetables are provided." Meals for people with dietary needs were available including vegetarian meals. One person said they felt the food could be improved and a social worker for one of the people who lived at the said they were aware this person did not always like the food.

Food stocks were plentiful and included a mixture of fresh, chilled and frozen food. There was fresh fruit available.

People said how they were also able to help themselves to food and could prepare light meals and snacks in a kitchen specifically for their use between meal times.

Records showed staff supported people with their health care needs. The service had links with local health care services, including GPs, community nurses and mental health services. Records showed people were supported with lifestyle health care needs such as giving up smoking and the provider confirmed this had been successful for several people. Care records also showed mental health and physical health care needs

were assessed with corresponding care plans of how to support people with these. Arrangements had been made for people to have specialist assessments and treatment where needed such as for eye care and dental care. A social worker for one of the people at the service said how staff had been successful in supporting a person to attend appointments where this had been a problem for the person in the past. Staff also told us how some people needed support to attend health care appointments, such as with their GP. People said how staff helped them with their health care needs. Records showed staff contacted health care services when people exhibited symptoms of illness to ensure people got the right health care checks and treatment.

Good

Is the service caring?

Our findings

People described the staff as caring and as having time to talk to them. For example, one person described the staff as, "Very kind. Very considerate. I can talk to them. They have time to talk to you. They are understanding of mental health needs." People said they were able to be independent such as going out to community events and places. People also said their rights as an individual were acknowledged such as being involved in decisions about their care and that their privacy was respected.

People and staff described the service as small, informal, homely and like a family. For example, a staff member said "It's not like a care home., It's their home. We try to be a bit more relaxed. You have to treat it as a family home."

We observed staff had positive working relationships with people and that people were comfortable approaching staff. One person we spoke with described how they experienced emotional distress from time to time and that staff were able to help them with this, but also said staff allowed them the space and time to resolve it themselves. Care plans also detailed how staff should support people with emotional distress by providing comfort and reassurance.

A social worker for one of the people who lived at the service described the staff as skilled in supporting people by allowing people to discuss their feelings; this included support to people who had experienced bereavement. The social worker also said the approach of the staff enabled people to develop confidence and independence following a move to the service. They commented that staff were skilled in building working relationships with people which had a positive outcome for them. Records showed staff supported people by the provision of discussion, listening and counselling regarding emotional, relationship and sexual health needs. This demonstrated staff listened to and valued people who in turn felt able to seek this type of support. This support also helped people to maintain relationships.

People said how they were able to choose how they spent their time and that there were no unnecessary restrictions on what they did. Staff also confirmed people exercised independence on how they spent their time. This ranged from going to the shops, preparing food and administering their own medicine. People's care plans were individualised to reflect each person's needs and preferences. These included support with care and the preferred name people wish to be called by. Care records also showed people were consulted about how they wanted to be helped. A staff member told us how people were "involved in decisions about what they wanted to do."

There were opportunities for people to contribute to decision making in the home at the residents' meetings. One person we spoke with said the following regarding the residents' meetings, "We are respected. Staff listen to and respect us."

The service had policies and procedures regarding people's privacy and dignity and people's rights. These were reflected in how the staff and culture of the service. People told us they had a key to the front door so they could come and go. Staff said how they promoted people's privacy by asking permission before going

into their rooms and people said staff knocked on their bedroom door before entering. People were also able to have a key to their bedroom door for privacy and security. The service had CCTV installed in some communal areas. There policies and procedures for this, which were for reasons of security. Records showed people were aware of this and that it was discussed at a residents' meeting.

Good

Is the service responsive?

Our findings

People were involved and consulted during the assessment and review of their needs. Conversations with people showed how people were involved in discussing and planning how their needs were to be met. Care records also showed people were involved in assessing their needs which included assessments of risk. People described the staff as responsive to their needs and requests.

People said there were a number of ways the provider and staff listened to their views and concerns. These included discussion at residents' meetings, care reviews or by approaching staff directly with any issues they had. People said the staff listened to their views and said they knew they could use the complaints procedure if they needed to.

A social worker for one of the people who lived at the home commented on how well the provider and staff responded to the initial referral for a placement at the service. The referral was said by the social worker to have been dealt with promptly and resulted in significant improvements for the person's well-being, mental health and confidence.

Care records showed people's health and personal care needs were comprehensively assessed and that care was arranged to meet those assessed needs. Care plans showed care was individualised with bespoke arrangements based on each person's needs and preferences; this is called person centred care. For example, there were different arrangements for each person regarding the support they needed with their medicines. Other examples of person centred care were evident in care records in sections entitled, 'Who I would like to be involved in my care,' 'Things that I am able to do,' and, 'Things that I would like you to help me with.' Each person had a named staff member called a 'keyworker' who took a lead responsibility for coordinating their care and support.

Mental and physical health needs were included in the assessments and records showed the staff were responsive to people's changing needs. For example, medical assistance was sought when people were unwell and less urgent needs were referred to the appropriate agencies. Charts were used where appropriate to monitor changes in behaviour or for other needs. Care needs were reviewed on a regular basis so arrangements could be made to meet changing circumstances. We observed a staff handover meeting when the staff teams changed shift where people's needs were discussed such as behaviour or people's mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs.

The staff sought to enhance people's independence and involvement in the community and in the way the service ran. For example, people were supported to take part in cooking, cleaning and their own laundry. Support was given to people to access community facilities and people could do this independently if assessed as safe to do so. A social worker for one of the people who lived at the service said how staff had arranged for numerous activities for people over the Christmas period and that staff assisted people to attend events outside the service. Records were kept of activities undertaken by people such as shopping trips and crafts. We observed people going out independently, playing darts and socialising with each other

or spending time in their rooms. There was a computer available for people to use, which included access to the internet. This meant the service promoted people to have a fulfilled lifestyle which included contact with other people both inside and outside the home.

The service's complaints procedure was displayed in the hall so people could access information about how to make a complaint as well as information about how any complaint would be dealt with. The complaints procedure was also included in a 'Residents' Handbook,' which also had details of any advocacy services people may wish to use if they needed support in making a complaint. The provider told us there had been no complaints made about the service in the last 12 months.

Good

Is the service well-led?

Our findings

People told us they considered the service to be well-led. For example people said they felt able to approach the provider if they had any concerns and considered these would be dealt with to their satisfaction. The views of people who lived at the home were incorporated into the way the provider and staff ran the service. People said there were opportunities to express their views about the service at the resident's meetings and in survey questionnaires. People gave examples of how their views were considered in planning the meals and in the type of activities offered.

There was an ethos where people were involved in the day to day running of the service which helped to keep people active and purposeful which in turn assisted their mental health needs. Routines in the service were arranged around people's needs and their preferences. This included people being involved in choosing colour schemes when redecoration took place, menu planning and being able to contribute to the process of recruiting new staff. Staff demonstrated how the service acknowledged people's rights of self-determination and independence whilst at the same time taking steps to keep people safe.

The service sought the views of people, relatives and health and social care professionals regarding the service provision. Results of the surveys showed people, relatives and professionals were satisfied with the standard of care at the service. The provider told us how surveys were sent out in response to any issues raised as well as on a regular routine basis. Records of residents' meetings were maintained and showed people were able to contribute to decisions about activities and menus.

At the time of the inspection the service did not have a registered manager but the provider had applied to the Commission for registration as the registered manager. A social worker for one of the people who lived at the home described the service as well-led with particular reference to the provider being approachable and committed to working with other services. The provider had a copy of the Care Quality Commission document, 'Residential adult social care. How CQC regulates.' The provider was knowledgeable about the methodology used to assess adult social care. The service had a line management system consisting of a deputy and senior care staff on duty who had responsibility for decision making in the absence of the provider.

Records of staff meetings were maintained and showed the staff team discussed how the service operated which included medicines procedures, keyworking with people, the provision of activities, and staff arrangements. The provider was able to monitor staff performance by the use of supervision and appraisal. Staff reported they worked well as a team and considered the staff team was well-led by the provider.

Untoward incidents and errors were looked into and there was a record of these along with any action being taken to prevent or reduce the chance of a reoccurrence in the future.

The provider carried out audit checks and there was an annual development plan. Whilst a maintenance book identified faults in the premises there was no recorded plan of how the decorative defects were to be addressed. We have addressed concerns about the premises in the 'Safe' section of this report.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not fully assessed the risks to service users or doing all that was reasonable to mitigate those risks. The provider had not ensured the premises were fully safe for their intended purpose. Regulation 12 (2) (a) (b) (d)