SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

Tylden House
Dorking Road
Warnham
Horsham
West Sussex
RH12 3RZ
Tel: 01403 242278
www.sussexhealthcare.co.uk

Date of inspection visit: 3 November 2014
Date of publication: 26/03/2015

Ratings

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

Overall summary

The inspection took place on 3 November 2014 and was unannounced.

Orchard Lodge provides personal and nursing care for up to 33 people with learning and physical disabilities, including two respite places. Most people have complex mobility and communication needs. Orchard Lodge is made up of two purpose built bungalows, Orchard Lodge which consisted of two units and Boldings Lodge. At the time of inspection, there were 31 people living at the service, with an approximate age range of 20 to 50 years old.

The service has a registered 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was in day to day charge at the service but had taken up a new role with the provider. The provider was recruiting for someone to take over as manager.

We observed that some people had equipment that restricted their free movement. Two people had stair gates across their bedroom doors and one person had a high-sided bed. Where people lacked the capacity to consent to these decisions relating to their care or treatment, the manager was unable to demonstrate that best interest decision making procedures had been followed. There was a risk that people could be deprived of their liberty without appropriate safeguards in place because the manager had not carried out assessments in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Suitable arrangements were not in place to monitor the status of staff training and to ensure that staff received refresher training in accordance with the provider's policy. Some training had not been refreshed annually, as was the provider's policy. While staff told us that they felt supported and that they had supervision meetings, we found that the manager had not conducted appraisals with staff.

There was a varied activity programme though records relating to people's participation were incomplete. On the day of our visit people were engaged in organised activities such crafts, exercise and music.

People, their relatives and staff spoke positively about the service. There was a friendly atmosphere and people were treated with kindness and respect. Support was given in a caring way that helped people to maintain their independence as far as possible. Staff were able to communicate effectively with people, both verbally and by interpreting their body language or sounds. They were able to involve people in decisions relating to their care and how they wished to spend their time. Despite these positive findings, we observed a few occasions where people were not treated with dignity. We discussed these with the manager before leaving.

People felt safe living at Orchard Lodge. There were enough staff on duty to promote people's safety. Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely and at the right time.

People's care was planned and reviewed on a regular basis. Where support from external healthcare professionals was required, the service had made timely and appropriate referrals. People were offered a variety of food and drink and were supported to eat and drink enough to meet their needs.

Staff were knowledgeable about people's care needs and preferences. One member of staff told us, "It takes time to learn people's needs. It starts with care plans, then you get to know the needs and look for various communication including body language and facial expression". People, their representatives and healthcare professionals were involved in reviewing their care to ensure that it met with their needs and preferences. People and their representatives were able to share their views. They told us that issues raised had been addressed and overcome.

The provider had a system to monitor and review the quality of care delivered. This included internal audits at manager and provider level, as well audits by external companies. Action plans were in place to monitor progress. Whilst we saw that these had been used to improve the service in many areas, they had not identified some concerns, such as the absence of staff appraisal.

The service was well-led in most areas and people felt able to approach the manager. A change in the management of the service was planned. **We recommend** that the management arrangements for the service be confirmed at the earliest opportunity to ensure clear accountability and oversight.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People said they felt safe. Staff understood safeguarding including the signs of abuse and what action to take.

Staff numbers were sufficient to meet people's needs safely.

Risk assessments were in place and regularly reviewed to ensure people were protected from harm.

Medicines were stored, administered and disposed of safely.

Good

Is the service effective?
The service was not effective.

People may have been unlawfully deprived of their liberty. Where people lacked capacity to consent to certain decisions, the manager had not followed best interest decision making procedures.

Staff had not had appraisals and some staff had not received refresher training to support them in their responsibilities.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to health care professionals to maintain good health.

The premises were purpose built to cater for people's mobility and support needs.

Requires Improvement

Is the service caring?
The service was caring.

People told us that they were happy living at Orchard Lodge and that the staff were supportive.

Staff involved people in making decisions relating to their daily needs and how they wished to spend their time.

People were treated with dignity and respect.

We observed a small number of occasions where staff did not support people in a way that promoted their dignity. We discussed these observations with the manager as they were not representative of the good care that we observed overall.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People's care was reviewed on a regular basis to ensure that it met their current needs.

People were supported to participate in activities.

People, their representatives and staff were able to share their experiences and any concerns, which had been responded to promptly.

Is the service well-led?

Requires Improvement

The service was well-led in most areas.

There was a friendly atmosphere at the service. People, staff and relatives felt able to share ideas or concerns with the management.

The provider and manager used a series of audits to monitor the delivery of care that people received and to make improvements. We found, however, that the system of audits had failed to identify some shortfall in the quality of the services provided.

Orchard Lodge

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 3 November 2014 and was unannounced.

Three inspectors undertook this inspection.

Prior to our visit, we reviewed previous inspection reports, the outcome of a safeguarding investigation from June 2014 and notifications received from the manager prior to the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we understood what the service did well and potential areas of concern.

During our inspection, we observed care and 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. We also spent time looking at records, including six care records, five staff files, medication administration records (MAR), accident and incident records, activity records, staff training and supervision records, completed feedback surveys and other records relating to the management of the service.

We spoke with six people using the service, two relatives, the registered manager, two nurses, nine care staff, the chef, a representative of the provider and a physiotherapist employed by the service. After the inspection, we contacted two relatives and three professionals who have involvement with the service to ask for their views.

This was the first inspection of Orchard Lodge since there had been a change in the provider's legal entity in October 2014.

Good

Is the service safe?

Our findings

People told us that they felt safe. They said that they would speak with the manager or a member of staff if they had any problems. Safeguarding information was available to people in an easy to read format which included symbols to aid understanding. Although not all staff had attended refresher training in safeguarding adults at risk, the staff that we spoke with all demonstrated a good understanding of their responsibilities. They were able to describe different types of abuse and the actions they would take to protect people. We asked staff what they would do if they were concerned that a colleague was putting people at risk. One said, "I care about the residents so I would report it regardless. I would go even higher if I thought the manager did not take my concerns seriously".

Risks to people's safety had been assessed. Most people required mobility support and specialised equipment such as hoists to transfer. The moving and handling assessments were detailed and gave clear instructions to staff regarding the equipment required and how to use it safely. For example, information on which sling should be used to help a person transfer from bed to a wheelchair or for use in the swimming pool were documented. There were also risk assessments around equipment such as lap belts, chest straps and knee blocks. The assessments specified how and when the equipment was required, for example only when using transport. In each case the hazard and measures in place to reduce the risk were described. The physiotherapist on duty told us, "There are regular checks on equipment and we make sure they feel safe. That is our priority here". Where accidents or incidents occurred, these had been recorded and reviewed. A monthly audit was completed and used to identify any patterns or trends. One such trend was that several people had injured their arms when going through doorways in their wheelchairs. This had been discussed with staff to raise their awareness and help them to keep people safe.

Prior to our visit, we had received concerns about insufficient staffing that was impacting on people's care and the activities available to them. Staff that we spoke with during the visit were satisfied with the staffing level. One said, "We've gone back to previous levels so it's alright". Staffing rotas confirmed that there were at least two nurses on duty during the day. The manager informed us that they had recruited additional nursing staff so that they could have three nurses on duty, one in each part of the service. Each part of the service was staffed by four care staff during the day, which included 1:1 support for one person. Staff were attentive to people's needs and responded quickly when assistance was required. One relative told us, "There's always somebody on hand. They seem to be there for them". A member of staff said, "We spend time with everyone. Sometimes if there is staff sickness we can't spend a lot of time, but we aim to".

Staff recruitment was safe. Before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers. This helped to ensure that they were safe to work with adults at risk.

People received their medicines safely. We observed parts of the medication round during the morning and afternoon in different parts of the service. Some people received their medicine orally, whilst others were administered theirs via a tube directly into their stomach. Medicines were administered by nurses safely and correctly. Where people had been prescribed medicine on as 'as required' (PRN) basis there were clear instructions for staff. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. Staff showed a good understanding of assessing pain for people who were not able to verbalise. This included observation of people's behaviour, expressions and gestures. They also used a recognised pain scale to aid the assessment and ensure people's pain management was appropriate. Records for the administration and disposal of medicines were complete and up-to-date. Medicines, including controlled drugs, were stored safely and recorded appropriately.

In the medication room at Boldings Lodge we observed two oxygen cylinders that were not labelled. The nurse told us that these were for people who may have a seizure. We discussed this with the manager as oxygen should be prescribed individually as part of a person's treatment plan.

Requires Improvement

Is the service effective?

Our findings

Some interventions implemented by staff restricted people's freedom of movement. We observed two stair gates used to prevent people from leaving their bedrooms. Others were restrained in their wheelchairs by straps or knee blocks and one person slept in a bed enclosed by high Perspex sides that were locked from the outside. The service had given consideration to risk but there was no record that consideration of people's best interests had been made. Best interest meetings should be convened where a person lacks capacity to make a particular decision; relevant professionals and relatives consider decisions on a person's behalf. This had not been done. This meant that staff were not following the Mental Capacity Act 2005 (MCA) when people lacked the capacity to consent. In the case of the gates and customised bed, the manager explained that these were in place at the request of people's relatives. The provider's policy on capacity and consent stated that, 'It is important to keep good records of assessments of capacity and best interest decisions made on behalf of a service user who lacks capacity'. There was no evidence that less restrictive alternatives had been considered. As the people concerned were adults, best interest decision making procedures should have been followed.

The manager was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 but told us they had not yet taken action in respect of this. A deprivation of liberty occurs when the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. The manager told us that they had made one application under the Deprivation of Liberty Safeguards (DoLS). We asked to see this paperwork but it was not provided. In some care plans we saw that a deprivation of liberty checklist had been completed. These were dated as far back as 2009 and did not appear to have been reviewed. The checklist had not been updated to reflect the revised test. Staff that we spoke with did not have a good understanding of the MCA and DoLS. Training records indicated that approximately one in five staff had attended training in the MCA outside of their induction period. There was a risk that people could be deprived of their liberty without appropriate safeguards in place. All of the above meant that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Staff were satisfied with the training opportunities available to them and told us that they were supported to pursue additional training. However the manager did not have suitable arrangements to monitor the status of staff training and ensure that staff received refresher training in accordance with the provider's policy. Safeguarding was listed as an essential training course to be followed by all staff on an annual basis. We noted that more than half of the staff had not attended an update within the last 12 months. In the training records for 2013 we found gaps in the provider's essential training (fire, moving and handling, safeguarding) for all staff. This meant that staff may not have been supported to care for people safely and to an appropriate standard. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff felt supported and told us that they were able to approach the manager if they had any concerns. Supervision records confirmed that all staff had received at least three supervision sessions in 2014. Each supervision included a review of previous targets and a discussion around future training wishes or development needs. We saw that one member of staff had expressed an interest in becoming a mentor for new staff members and had been put forward for this training. Apart from one appraisal in 2014 there were no recorded appraisal meetings in 2013 or 2014. Staff may not have received appropriate support and supervision in relation to their responsibilities which could impact on the care that people received. A system of appraisal is important in monitoring staff skills and knowledge to enable them to deliver safe care. This shortfall was not in line with the provider's policy of annual staff appraisal and was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

New staff joining the service attended an induction programme. The provider had introduced an enhanced induction course at the beginning of 2014.This combined classroom training with time shadowing experienced staff. One member of staff who had recently started spoke enthusiastically about their induction and all the training they had received.

Requires Improvement

Is the service effective?

People's care had been planned and was regularly reviewed to ensure that it was appropriate and met their needs. Following an initial assessment, care plans had been written to describe the support each person required, including with mobility, communication, nutrition and hygiene. Care plans around communication were particularly detailed. This was essential because many of the people living at Orchard Lodge were unable to communicate verbally. Staff had also completed assessments using the Disability Distress Assessment Tool (DisDAT tool). This described people's usual appearance, vocal signs, mannerisms and posture when they were content or distressed. Staff told us that the care plans supported them in their work. One said, "We should know what's in the care plans before doing any tasks. It's really important as they can't tell us what they want or need". Another told us about a person whose movements could be misinterpreted. They explained, "They may appear aggressive but is very placid and jerking movements are part of his physical disability that affects his nervous system. Knowing things like this is very important".

People were offered a variety of food and drink and were supported to eat and drink enough to meet their needs. One relative told us, "I find them fantastic. He's not a good eater but they keep persevering and gently coax him. He has a peg (a tube that provides nutrition directly into the stomach) but this is only used as a last resort. They give him lots of time and don't rush". Another said, "He's very well fed, in fact he has put on weight and that's good". We carried out an observation over the lunchtime period. People received support from staff to choose their meal and to eat at a pace that was comfortable for them. Soft and pureed meals were presented in an appetising way. Where possible, people used specialised equipment such as non-slip mats, adapted cups and cutlery to enable them to eat independently. The menu took into account people's individual likes and dislikes. The chef also gathered feedback from people and via staff who had supported them. Each week a selection of meal check forms were completed and reviewed by the kitchen staff. The chef shared examples of individual tastes that they catered for, such as one person who liked spicy food and another for whom they kept a supply of homemade chocolate cake for dessert. Most people were weighed on a monthly basis and this information was shared with the chef. As part of this monthly review we noted that changes were introduced. One person was now having skimmed milk to support their efforts in losing weight. Others, who were at risk of malnutrition, had gained weight as a result of dietary interventions put in place.

People were able to access healthcare professionals. People had regular access to services including their GP, chiropodists, opticians and dentists. One relative told us, "The doctor comes weekly. He just had his flu jab. They keep up with things like that. He has his hair cut every six to eight weeks and the chiropodist visits at about the same frequency too. We couldn't ask for more from the staff". A healthcare professional told us that staff provided them with good information about people's health and made appropriate decisions as to when to contact them for further advice.

People's mobility and sensory needs had been considered in designing the premises, which had been purpose built. Bedrooms and bathrooms were equipped with tracking hoists. Most bedrooms had en-suite facilities. The service also had adapted bathrooms to enable people to bath safely. We observed that one of these bathrooms had been decorated with hand-painted murals which made the room inviting. There were also two spas and a swimming pool on site for physical therapy and leisure. The paths and gardens had been made accessible by pathways and ramps that were comfortably wide for wheelchair use. In a central courtyard we saw a fishpond and lots of sensory wind chimes. During the afternoon we observed people watching a film on a large screen television that had surround sound that amplified vibrations. This provided a good sensory stimulation for people who appeared to enjoy the experience and relax at the same time.

Good

Is the service caring?

Our findings

People were supported by a staff team who knew them well. The manager rarely used agency staff, favouring the use of bank staff where shifts needed to be covered as this provided more continuity of support. Staff demonstrated skill and understanding when communicating with people. They were able to interpret non-verbal signs and respond accordingly. A member of staff explained that one person who appeared to be sleeping was actually awake. The staff member said, "He's just resting his eyes. They flicker which means he is listening". When the member of staff mentioned the person's name his eyes flickered as described by the member of staff. Another person gestured to a member of staff to hold their hand. The staff member responded immediately and the person appeared very happy and relaxed in their company. One member of staff said, "We are committed. We relate to people. By a look from someone, I know what they want". Staff were able to describe the signs to look for when people were unhappy and what they did in response, such as suggesting their favourite activities. One member of staff explained, "If he doesn't want to do something he is very good at letting you know. He will push you or the object away. If he pulls his scarf over his face this usually means he is happy and content".

People were encouraged and supported to maintain relationships. Relatives spoke positively about the support that staff provided. One said, "The staff don't look on it as a chore, they treat her like one of the family, to give her the best quality of life". Another told us, "He's so happy there. I get a giggle when I take him out. When I get him ready to take him back he giggles all the way". They also described particular situations where the actions of staff had made a real difference, for example, "When he first went there he wouldn't let anyone shave him but then one time the carer sang to him and that turned him around". They spoke of the friendliness of staff and the fact that they were able to visit at any time. One relative told us, "There is a room upstairs that families can use. This is great if our son is not well. We have used it when he was ill; it was lovely to be so close".

People were involved in making decisions about their support. Information about life at Orchard Lodge was available in an easy to read format. It included information about visitors and sharing their views. One relative told us, "My son did have a few problems to start with but everyone rallied round and made him feel so welcome". Some people invited us to see their bedrooms. We saw that they had personalised their rooms. Where possible, people had been involved in review meetings relating to their care. These meetings also involved representatives and considered input from the health and social care professionals who were involved in the person's care. One relative told us, "They encourage her to make decisions as far as she is able"

People were treated as individuals and staff knew what was important to them. People's care plans included details about how they liked to dress and the type of activities they enjoyed. Although people were not always able to attend worship in the community, staff supported them with their spiritual needs. One person enjoyed listening to an audio version of their religious text and staff put this on in the evening for them. Staff encouraged people to be as independent as possible. We observed two members of staff assisting one person to move from a bean bag to a wheelchair. They tried to involve the person and encourage them, for example by counting to three and rocking the person so they had the momentum to stand. This took three attempts but allowed the person to do as much as possible for themself. One relative told us, "They are encouraging him to do lots of things".

On the whole staff treated people with privacy and respect. When a member of staff noticed that a person had a wet patch on their trousers, they discreetly asked if the person would like to go and get changed. Others wore neck scarves to protect their clothes from saliva. These could be changed frequently to ensure that the person was comfortable and happy with their appearance. Most staff chatted and engaged with the people they were supporting, whether or not the person was able to verbally respond. On many occasions we saw that people were alert and watching.

We also observed some staff interacting with people in a way that did not uphold their dignity. Two people were moved in their wheelchairs without prior warning, the television channel was changed without any discussion with those who were watching it and a member of staff called out over a person saying, "What does he want to drink?" We also observed that some nursing procedures were carried out in communal areas. These examples did

Good

Is the service caring?

not demonstrate a dignified and respectful treatment of people. We discussed these observations with the manager as they were not representative of the good care that we observed overall.

Good

Is the service responsive?

Our findings

During our visit people were involved in a variety of activities, including craft, music, games and exercise. Others attended college in a local town or day centres at other services run by the provider. One person showed us photographs of recent activities and outings that they had enjoyed. We observed that whilst most people were unable to participate directly in the activities taking place, they appeared involved. For example, their eyes watched and moved when shown different elements, smiling and making sounds that appeared positive. Staff sat next to people and gained eye contact. We heard staff involving them, asking, "Do you like this colour?", "Shall I use this card?" One relative told us that the service had arranged for their son to try fishing which had proved to be a success. They told us, "They don't let him sit around and do nothing". A visiting professional said, "My experience leads me to believe service users are happy here. I've seen lots of activities when I visit. I'm very impressed with the service".

Activity records did not reflect the varied activities that people, relatives and staff described. For example, we read, 'No driver today' or '(Activity coordinator) on holiday' as the description of what people had been involved in. We also noted that there were fewer activity staff in school holidays. This impacted on some of the activities that people were able to participate in as additional staff were required for outings or to assist people to use the swimming pool. We discussed this with the registered manager during our visit.

Staff were knowledgeable about people's care needs and preferences. People's care records were personalised and had been reviewed to reflect changes that occurred. Where staff had noticed that a person was struggling or required additional support, solutions were explored. One relative told us, "He has to have some tablets crushed up but they got the GP to approve this first to make sure he gets the tablets he needs in a way that he can swallow". We received feedback from one GP practice. They told us that they found the service to be, 'Very responsive to residents' needs and their relatives' concerns'.

The service was responsive to feedback from people, their relatives and representatives. People were able to share their views at residents' meetings. In the minutes of a recent meeting we saw that entertainment, forthcoming events and introductions to new staff had been on the agenda. Relatives were asked to provide feedback on the service in the form of questionnaires. These were sent by the provider throughout the year. The most recent responses indicated that relatives were satisfied with the service provided. Where there were issues, these had been addressed. One relative told us, "If there has been a problem, it's always been overcome". Another said, "We feel comfortable to say something if we are not happy".

People and their relatives understood how to complain. The complaints procedure was displayed and was also available in an easy to read format. Where complaints had been received, these had been thoroughly investigated and responded to. The records included a summary of the complaint and the action taken. In August, the service had collaborated with Healthwatch (the consumer champion for health and social care) on a study in to care home complaints, aimed at helping care homes to learn more from complaints and feedback. As a result of a recommendation, the provider was considering adding a statement in the complaints notice and policy to make clear that care would not be affected if someone should make a complaint.

Requires Improvement

Is the service well-led?

Our findings

The quality of the service was monitored by a system of internal, provider-level and external audits. There was good evidence of the system identifying and driving improvements. We, found, however, that the systems in place had not identified the shortfall in refresher training and appraisal, or the absence of best interest decisions in cases where they were needed. This meant that the systems were not comprehensive or consistently effective at identifying issues and making improvements in the quality of the services provided.

We looked at a selection of completed audits. Action plans were in place that detailed the responsible person and target timescale. Once completed actions were signed off and dated. For example, care planning documentation had been updated, activity schedules and future meeting dates had been displayed and improvements to the environment, such as fitting new carpet, had been agreed. We noted that over a six month period, the service had improved their health and safety score by six percent. The external company conducting the review stated that the service had made, 'A considerable effort to improve the standards of health and safety'.

A change in the management at the service was planned. The registered manager was still in day-to-day charge at the service but was in the process of transferring responsibilities. Some of the information that we requested was held by the acting manager and the manager deferred to them for answers. In their new role, the manager was responsible for monthly audits at the service on behalf of the provider. This meant that they were auditing their own service as they were still involved in day to day management. **We recommend** that the management arrangements for the service be confirmed at the earliest opportunity to ensure clear accountability and oversight.

There was a friendly atmosphere at the service. People, relatives and visitors spoke positively of their experiences. There was a core team of staff who knew people well. They had developed a rapport with people and understood their communication. We saw that people spent time in different parts of the service to see friends who lived there or to participate in activities. People were encouraged to be as independent as they were able. One member of staff described equality and diversity as, "Treating people differently but giving the same opportunities regardless of their abilities". We found that the relationships fostered a positive environment. One relative said, "It doesn't feel like an institution, it's a home".

People, relatives and staff told us that they felt confident to approach the manager. One member of staff said, "The manager is approachable and very helpful to me". Another told us, "There is good communication and the door is always open to management". Staff told us that they understood their responsibilities and what was expected of them. We noted that there were regular staff meetings and that future meeting dates were displayed.

The service had been accredited under the Gold Standards Framework (GSF) in 2011. GSF focuses on end of life care. It describes itself as about, 'Quality care, quality improvement, quality assurance & quality recognition'. The accreditation process involves continuous assessment against standards of best practice across a two year period and an official inspection visit at the end.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them, or for establishing and acting in accordance with their best interests.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person had not ensured that suitable arrangements were in place for staff training and appraisal.**