Barchester Healthcare Homes Limited

Bloomfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

We undertook an unannounced inspection of Bloomfield on 21 March 2017. When the service was last inspected in August 2016 we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

As a result of the findings of the inspection in August 2016, we served two Warning Notices in relation to the management of medicines and governance. We returned to Bloomfield in November 2016 to ensure action had been taken in relation to the Warning Notice served around the management of medicines. The service had achieved compliance with that part of the regulation during that inspection.

In addition to the Warning Notices, we set requirement actions in relation to the other breaches of regulations. The provider wrote to us in September 2016 to tell us how they would achieve compliance with these requirements which we reviewed during this inspection. In addition to this, we also followed up compliance against the Warning Notice served in relation to governance.

Bloomfield provides accommodation for people who require nursing or personal care to a maximum of 102 people. The accommodation is set over two floors with four separate areas. These were 'Ash Way' and 'Salisbury Rise' which provided general nursing care and treatment to people. The 'Beech Walk' and 'Mendip View' accommodation provided care and support to people living with dementia. At the time of our inspection, 67 people were living at the service.

A registered manager was in post at the time of inspection. They had registered with the Commission in July 2016. 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.

Although we found some improvements during this inspection, the service was unable to demonstrate they had fully complied with the requirements of the Warning Notice in relation to governance. Although we found a reduction in recording errors and omissions by staff, we still found recording errors in relation to the planning of the care and treatment people required. We also found errors in the daily records that showed if people had received care in accordance with their assessed needs. This demonstrated that governance systems were not effective in identifying the recording errors.

We found evidence that people had not received care in line with their assessed needs and the provider had failed to consistently ensure enough staff were deployed to meet people's needs. We received information from people and their relatives on how this had resulted in a negative impact on care delivery and we made observations to support this during the inspection. The service had not ensured that all legal notifications had been sent to the Care Quality Commission.

The current identified shortfalls are of particular concern as there are continued breaches of some regulations and the service is currently running at limited occupancy level. A further increase of people being accommodated may result in further negative outcomes for people receiving care and treatment at Bloomfield.

People at the service commented they felt safe. People received their medicines when they needed them and there was a system to review reported incidents and accidents. There were safe recruitment processes in operation and staff understood their obligations to safeguard people. People's risks were assessed and the service was clean. Checks on the environment and equipment within it were completed.

The service had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We saw examples of how the service had involved people and their representatives in decision making processes. People said they received effective care. Appropriate referrals were made to healthcare professionals when required and we received positive feedback from GPs that attended the service. There were systems to support staff through training, supervision and appraisal.

People said that staff were caring and we made some observations to support this. However, we also made some less positive observations of interactions between people and staff. We also made observations of how poor staffing levels impacted negatively on people's care. Staff we spoke with understood the people they supported well and people's visitors were welcomed at the service. There were advanced care plans in place to support people at the end of their lives, however we did find an example of when this was not followed.

Care plans were person centred and showed people's preferred routines and communication needs. People's life histories were documented to assist staff in knowing and understanding the people they supported. There was a complaints procedure in operation and people had the opportunity to participate in activities. We received mixed feedback from people and staff about the management of the service. There were systems for the management to communicate with staff, people and their relatives. There were some effective governance systems to monitor people's health needs and the service received support from the provider.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a continued breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. 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?

Requires Improvement

The service was not consistently safe.

There was not always enough staff to support people safely.

Accidents and incidents were investigated.

People's risks were assessed and risk management guidance was completed.

People received their medicines as prescribed.

Recruitment procedures were safe and the environment was maintained.

Is the service effective?

Good

The service was effective.

People felt they received care from competent staff.

The service was meeting the requirements of the Deprivation of Liberty Safeguards.

People received the support they needed to eat and drink.

Staff received training, supervision and appraisal.

People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People spoke positively of the staff at the service.

Current staffing levels impacted negatively on people's care delivery.

We observed positive and less positive staff interactions with people.

People's visitors were welcomed.

End of life care wishes had not been consistently followed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always accurate, placing them at risk.

People felt staff were responsive.

Complaints had been acted upon when received.

There were activities for people at the service to partake in.

There were links with the local community.

Is the service well-led?

Inadequate

The service was not well led.

A legal notification had not been sent as required.

Governance systems were not sufficiently robust to identify recording errors.

People were not always positive about the management of the service.

There were systems to communicate with staff.

Some effective governance systems were in operation.

Bloomfield

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 carried out by four inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. When the service was last inspected in August 2016 we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

Before the inspection we reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us. We also looked at 15 people's care and support records.

We spoke with 25 people who used the service and four visitors. We also spoke with 15 members of staff. This included the registered manager and the deputy manager. Following the inspection, we also contacted numerous health and social care professionals who have regular contact with the service. We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Requires Improvement

Is the service safe?

Our findings

At the inspection of Bloomfield in August 2016, we found that the provider had not ensured that action had been taken to reduce or mitigate any risks associated with people following a fall or accident. We found that in excess of 40 incident and accident reports had not been fully completed and reviewed by senior staff or management.

The provider wrote to us in September 2016 to tell us how they would achieve compliance with this part of the regulation. During this inspection, we found the provider had taken action and a full comprehensive review of all reported incidents and accidents had been completed.

At our inspection of Bloomfield in August 2016, we received mixed feedback about the staffing levels at the service which we highlighted to the provider within the report. During this inspection, people and staff we spoke with again told us that they felt the service was not sufficiently staffed at times. We saw this had been reflected in some of the complaints we had received, and in addition some of the relatives and visitors we spoke with gave examples of when staffing levels had concerned them.

All of our inspection team made observations that call bells were ringing for long periods of time. In the morning, one person's call bell rang for 13 minutes before a staff member arrived to support them. Comments we received from people indicated the service was not always appropriately staffed. One person said, "I am very safe here because I can speak up for myself. There is definitely a shortage of staff, especially at night, and at certain times during the day such as when they are getting people up. If I ring my bell someone will come and ask if I can wait for five minutes, which can often turn into 20 minutes if there is someone in more urgent need than me."

Another person said, "Because staff know I am fairly independent, I am often left, it can be annoying, but I know there are a lot of people who need a great deal of attention, so I put up with it." A further comment was, "I have special equipment to make sure I am comfortable and can be moved and hoisted safely. On average, I have to wait 10 minutes for someone to come if I use my bell, I think they just about manage but one more member of staff on all shifts would make a difference." Another person said, "Staff are stretched to the limit, it is not too bad for me because I can manage to walk to the loo, but for others it is a big issue."

People's relatives gave negative feedback about staffing levels and gave examples of how this had impacted on people's care and support. One relative we spoke with commented on how they had complained to the service about the shortages of staff. They gave examples of how call bells were not being answered quickly. They told us that on one occasion this had resulted in their relative soiling themselves, which had caused them great distress. Another relative told how they were not currently satisfied about the care being provided and said they felt they must visit every day to check that things were being done. They gave examples of occasions when their relative was often wearing food stained clothing, and that their call bell was not within reach. This relative said call bells were constantly ringing and people were often shouting out.

The relative also told us that a few days prior to the inspection, they had heard a person crying and shouting out for help for what they described as a 'long time'. They said that as the person was sounding more and more desperate, they went to the person's room where they found them lying flat on their bed and not able to get up. The relative told us they walked up and down the corridors calling and looking for staff and eventually found a member of the kitchen staff who came to help, shortly followed by a member of care staff. This further demonstrated there was not always sufficient staff on duty to meet people's needs.

During the afternoon within the Beech Walk 'Memory Lane' area of the service, we saw how a person had not received the support they required. We entered the lounge and dining area at 3.05pm and saw that one staff member was supporting the seven people sat in the lounge. Six of these people were in armchairs within the lounge. One person was in a wheelchair and we spoke with the staff member on duty about this person. They told us the person had returned from an activity upstairs about 10 minutes before we arrived. It was then established the other member of care staff on duty was required to support someone in their room to change their clothing which was unexpected.

The staff member in the lounge told us they needed the second staff member to safely support the person to get out of their wheelchair and into an armchair. We remained in the lounge until the second staff member returned at 3.36pm to support the person in the wheelchair. This meant in total the person in the wheelchair had waited 31 minutes during our observation to be supported from their wheelchair, in addition to this the staff member told us they had been in the lounge approximately 10 minutes before we arrived but this time period was not observed by our inspection team. This showed that the current staffing levels had not ensured this person's needs were met. It was also observed that during the morning in Ash Way, people were left alone in communal areas for periods of time up to 15 minutes whilst care staff were attending to other people in their rooms.

The registered manager said there were only a few staff vacancies at the service. They told us the provider had a staffing level dependency tool known as the Dependency Indicator Care Equation (DICE) tool. This calculated current staffing levels. Staff gave mixed comments in relation to whether they felt there enough staff on duty to meet people's needs. Comments included, "We are fully staffed, but it doesn't feel like enough. I would like to have the time to sit and maybe read a paper with people." Another staff member said, "Put it this way, if we had more staff we could spend more time with people and that is the difference between good care and excellent care."

We spoke with some staff about the DICE tool. One staff member said, "Every day is changing so it doesn't always work. DICE works on the best case scenario." They then explained how people's care needs in relation to falls and skin care could change daily which impacted on staff requirements. Staff comments on different accommodation areas varied. For example, one staff member who worked on Ash Way where 25 people lived said, "I feel we are short on carers in the afternoon and at weekends, when we have no hostess in the servery." A person working on Mendip View where there were seven people living, felt that the staffing levels were, "Manageable at present with the numbers we have."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2016 we found that senior management had not done all that was reasonably practical to mitigate or reduce risks to people following an incident or accident. At this inspection we found that accidents and incidents had been reported fully by staff with all the information required. We saw that appropriate people were informed about an accident or incident, for example people's family members or their GP. We saw that where incidents reported required further investigation,

senior staff members had sought information and examined events. Accident and incident forms showed where other agencies such as the local safeguarding team or the Care Quality Commission had been notified. Accidents and incidents were reviewed by a manager to ensure effective action had been taken to prevent reoccurrence. An overview of all accidents and incidents was completed to monitor for any patterns or trends and ensure that preventative measures taken were effective.

People at the service felt safe with the staff who supported them. We received positive feedback from people we spoke with. One person said, "I think I am safe, I do not use the bell, they come in to see me and bring me tablets." Another person commented, "I am safe here, I am part of the community and they do their best to ensure I am well looked after, although their level of knowledge could be better." A further comment from a person was, "It is safe. It is private here - I like to sit on my own."

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. In addition, the service had ensured that where necessary a staff member's registration with the relevant body was current. This included nursing staff being correctly registered with the Nursing and Midwifery Council.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of alleged abuse. Policies and procedures were available to everyone who used the service. Staff confirmed they attended safeguarding training regularly. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, the Care Quality Commission and the Police. Staff spoken with confirmed that they had received safeguarding training. One said, "I have no concerns here, I'm happy with the level of care."

Registered nurses were responsible for the administration of medicines. We observed two nurses on part of their medication administration rounds and saw that they were organised and safe practice was observed. They were wearing red tabards with 'Do Not Disturb' written on them in order to ensure minimum distraction during the medicine round. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to.

One of the nurses confirmed that their competency to administer medicines had been checked during their initial induction training. We saw training records which confirmed this, and that the other nurses in the home had undertaken a comprehensive assessment of their competency. Competency assessments were held annually.

A selection of Medicine Administration Records (MAR) were reviewed. People's photographs were attached to their MAR sheets to aid identification. Any medicine allergies were recorded. MAR sheets were signed following administration and there were no omissions on the sheets we reviewed. Running totals of medicines in stock were being recorded where appropriate. Appropriate codes had been entered when medicines had not been administered. MAR sheets were being checked for discrepancies during shift handovers and then signed by a nurse. Individual protocols for the use of 'when required' (PRN) medicines were available. This is seen as good practice as it directs staff as to when, how often and for how long the medicine can be used and improves monitoring of effects and reduces the risk of misuse. We saw that these protocols had been reviewed monthly.

MAR sheets had been pre-printed by the pharmacy. There were occasional hand written amendments and additions. This was when staff had transcribed details of a prescription or alteration onto the MAR. We found that hand written amendments had been signed by the person who did the transcribing and that a witness signature had been obtained. Signing hand written amendments and getting them witnessed is seen as good practice as it reduces the risk of transcription errors.

Records relating to the application of prescribed topical medicines were seen in separate files that were kept in people's rooms. These were mainly complete, apart from two sheets that had one gap on each, when the application had not been recorded. Written details of how and where to administer the medicines were recorded. Body maps, to specifically indicate which area of the body the topical medicine should be applied to, were in use. One person had been prescribed transdermal patches. We saw that the location the patch was applied to on the person's body was being recorded.

Medicines were seen to be stored safely and appropriately. Medicine fridges were available to store those medicines that required it and the temperature was checked and recorded daily. The temperature of the medicine storage room, in which the medicine trolley was kept, was being checked to ensure that medicines were being kept at the correct temperature. The receipt and disposal of medicines was being recorded and witnessed by two people.

Controlled Drugs (CDs) were stored correctly and stock levels were checked daily. Disposal of CDs was recorded and signed and witnessed by two staff members. Stock levels of two CDs were checked and found to be correct. Frequent medicine management audits were being undertaken including a review during part of the 'Resident of the Day' governance audit. Medicine errors were being recorded along with details of any action taken.

A list of 'homely remedies' was available and their use had been approved and signed by a GP. Homely remedies are medicines such as throat pastilles and paracetamol that are available without prescription. Details relating to the use of homely remedies included symptoms for use, appropriate dose, frequency, maximum dosage in 24 hours and when to refer the person to their GP, were recorded.

All of the care plans we looked at contained risk assessments for areas such as falls, moving and handling, tissue viability and nutrition. Where risks had been identified, the care plans contained clear guidance for staff on how to reduce the risks and how to keep people safe. For example, one person had been assessed as being a low risk of falling. Despite this, they had fallen recently. The incident had been reported and investigated and a copy of the form was held within the care plan. The falls risk assessment had been reviewed following the fall and the care plan had been amended to reflect the increased risk. Previously, the person had been transferred using a stand aid. The care plan now stated that the person should be moved using a hoist later in the day, because that was when they were most tired, but that a stand aid could be used during the mornings if staff assessed this as safe. When we spoke with staff about this person's care, they knew the person had fallen and knew that the person's mobility varied according to the time of day.

People had been assessed for the use of bed rails to keep them safe when in bed. When bed rails had been considered, bed rails risk assessments had been completed in full and these assessments had been reviewed monthly. People had also been assessed for the ability to use their call bells. When people were unable to use their bell, the plan informed staff to check people regularly in order to ensure their safety. We saw that the associated checks had taken place and records showed that staff had completed them because they had been signed to indicate that staff had done so.

Some people had urinary catheters in situ. The care plans in relation to these people provided clear

guidance for staff on how to maintain the condition of the catheter and how to minimise the risk of infections. For example, one of the plans we looked at provided detail such as a description of what staff should observe for that might indicate an infection or a blockage. In addition, recommended fluid intakes were documented to ensure the catheter flowed well.

We found the service was clean. Communal areas and people's rooms seen were cleaned and odour free. Domestic staff were employed daily to maintain cleanliness standards. There was liquid anti-bacterial gel available at designated points around the building to promote good hand hygiene practice. Staff were observed wearing protective equipment when required which also reduced the risk of cross infection. People and their relatives we spoke with did not raise any concerns about the cleanliness of the service. Staff we spoke with told us the service was well maintained and cleaned.

The environment and equipment used within the service was maintained to ensure it was safe. The provider had dedicated staff at the service that monitored all aspects of the environment and the equipment. We reviewed information that detailed the regular maintenance and servicing of mobility equipment undertaken. Environmental aspects such as legionella risks and lighting were frequently audited. Mobility equipment such as hoists and slings were also subject to regular checks and servicing. Regular servicing and the testing of the fire alarm and associated fire fighting equipment was undertaken. It was noted during a review of the weekly fire alarm tests that a test had been omitted in November 2016 and a monthly inspection of the fire doors had not been completed in February 2017.

Good

Is the service effective?

Our findings

At the inspection of Bloomfield in August 2016, we found that the provider had not ensured that people who lacked the mental capacity to consent to care or treatment received care in line with the Mental Capacity Act 2005 legislation. In addition to this, we found the provider had not always met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA).

The provider wrote to us in September 2016 to tell us how they would achieve compliance with the relevant regulations. During this inspection, we found the provider had taken appropriate action.

An effective system was in place that showed who had a DoLS application and the status of their application. This also showed when the DoLS expired and when re-applications had been made. Two people had conditions attached to their DoLS authorisations. Conditions specify particular points that the service must arrange or facilitate for the person. Conditions are attached to ensure that a DoLS is in the best interests of the person. We found that these conditions were met. A list was displayed in the staff offices in each unit to ensure staff were aware who had an authorised DoLS in place. Staff we spoke with were aware who had a DoLS in place and what this meant for them.

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

Care records showed that people's capacity had been considered. For example, we saw an assessment had been made as to whether a person had the capacity to decide whether a sensor mat was used in their room to alert staff to their movement and help keep them safe. The outcome of the assessment was that the person did not have the capacity to make this decision. As a result, a best meeting was held with relevant others and a best interest decision made. However, we did see several best interest decisions made by just one member of staff without consulting family members or relevant others. We also viewed a best interest decision around a person's personal care. The outcome of the decision was recorded as, 'Maintain good hygiene.' However, the decision making process did not demonstrate how this would be achieved, what this actually meant or the options that had been considered and discounted.

Other evidence showed that care records contained mental capacity assessments and when best interest decisions had been made. Care plans contained details of these and the decision making process and who had been involved was clearly documented. For example, one person was unable to communicate verbally and unable to mobilise independently. It had been documented that the person became upset if other people using the service went into their bedroom. A discussion had been held with the person's advocate

and a best interest decision had been made regarding the use of sensor mat, which would alert staff if somebody entered the room.

In addition, clear decision making processes had been documented when other best interest decisions were made, for example, for the use of bed rails when people were unable to consent to their use. Where people received their medicines covertly, a mental capacity assessment in relation to medicine management had been carried out and a best interest's record form had been completed, which had also been signed by the person's GP and pharmacist.

Generally, we observed staff asking people for their consent prior to assisting them. For example, we saw one member of staff ask one person, "Would you like to come to the activity?" When the person said they weren't sure, the member of staff replied, "Why don't you come along with me, and if you don't like it, I can bring you back?" Another member of staff offered a person the choice of two options for breakfast, which they showed to the person to enable them to make their decision. We also heard staff used terms such as, "Can I help you to....?" and, "Would you like me to?" when speaking with people. However, we did also observe two members of staff assisting people with their lunch. They did not ask people if they wanted their lunch, and did not ask them if they liked it or if they wanted more.

People were mainly positive about the effectiveness of the care they received at Bloomfield. One person we spoke with commented, "Staff are competent and well trained, they sometimes 'Ask before doing' but they know my routine and mostly get on with it." Another person we spoke with said, "Staff are very competent and are perfectly ok." Another person said, "I do not need much attention and on the whole my needs are being met." One negative comment we received though was, "Some staff are better than others at knowing what to do. Not all staff are competent, they do not ask what I think, they just do."

People were supported to have enough to eat and drink. People had been assessed for the risks of malnutrition and dehydration and these were reviewed monthly. When risks were identified, care plans guided staff on how to ensure people received enough to eat and drink, and the frequency of monitoring people's weights reflected the assessed risks. For example, one person's weight records showed their weight fluctuated each month. As a consequence of this, the person's weight was monitored weekly until it had stabilised.

When weight loss was noted, advice and support was sought. Records showed that people had been reviewed by the Speech and Language Therapist (SALT) and that the care plans reflected their recommendations. When people were having their food and fluids monitored, charts had been completed in full. The daily targets were recorded and when people did not meet the daily target this was highlighted on the chart. Staff knew which people were having their intake monitored and knew when they needed to encourage people to eat or drink more. Where people had a Percutaneous Endoscopic Gastrostomy (PEG) tube fitted for liquid nutrition, they had a specific care plan in place and records indicated that the PEG was being managed appropriately.

We observed that generally nutrition plans were followed. For example, in one person's plan it had been documented that staff should cut the person's food up for them, but should encourage the person to eat independently. We observed that staff followed the plan of care for this person. They made sure the person was able to eat independently and then offered regular encouragement throughout the lunch period. However, we also observed one member of staff assisting a person with their lunch who was not following their care plan. The person had been assessed by the SALT team who had advised, 'upright position and alternate mouthfuls of food and small sips of drink.' Although the texture of the food provided was in line with the advice, the member of staff did not alternate food with small sips of drink. In addition, we observed

that they did not interact with the person verbally throughout the meal experience.

We also saw similar examples where one member of staff stood up whilst assisting one person (who was sitting down) with their soup and another member of staff who stopped assisting one person with their lunch in order to answer the phone. They did not tell the person what they were doing and did not apologise for the interruption which showed a lack of respect for the person they were meant to be assisting. This may indicate that additional training for staff maybe required to enhance the dining experience for people.

We received mixed feedback on the food. We were told that a new head chef was starting and was currently completing their induction. The same menu had been used for the past year in the service. Another chef told us that they felt the menu was not balanced, for example, the lunchtime and evening meal could both be beef or pork. We were also told that it was not always suitable for older people. It did not always include meals which they could recognise which we observed during the lunch time when staff had to explain to people a simplified description of the menu. The menu was also written in a way that people could not always understand. It would be more suitable for people living at the service if simpler words and descriptions were used. We observed people being offered different options to what was on the menu at lunchtime. A person specifically requested chips and was told this was fine and it would take five to ten minutes to cook. At breakfast people had whatever they wished from a large selection. Food was cooked to order.

People had access to on-going healthcare services. Care plans contained records from when people had been assessed or reviewed by the GP, SALT, physiotherapist and independent mental capacity assessors. Other records showed that people with diabetes had been seen regularly by their GP and a chiropodist. People we spoke with confirmed that they were able to see a GP when they wished. Following the inspection we made contact with numerous GPs that had regular contact with the service and the people living within it. Within the responses received, there was positive feedback. For example, a GP that attends the service told us the service passed their, 'friends and family' test and said the 'quality of care compares favourably to other nursing homes in the area.' Another GP told us, 'I really appreciate their regular checks of weight, blood pressure etc. This helps monitor patient's nutritional state and ensures appropriate patients are given supplements. Palliative care is particularly well performed and the nurses are competent in end of life care including syringe drivers.'

The provider had systems in place to ensure staff received supervision and appraisal. Staff we spoke with gave mixed responses on the frequency of their supervision. In general the staff we spoke with told us they had received supervision with a senior member of staff or had one pending soon. The registered manager and deputy were aware that there was a current shortfall in supervision and appraisal completion and were working to rectify this. This had also been identified by a senior member of the provider's management during a recent quality audit. We saw a 'supervision tree' showing which delegated senior staff were responsible for supervising certain staff and also that a schedule was in place for future supervision dates.

There was a training schedule that ensured staff received appropriate training to carry out their roles. Staff felt they were given sufficient training to effectively support people and meet their needs. Staff had received appropriate training in a variety of relevant topics to meet the needs of the people. This included moving and handling, health and safety, fire and safeguarding. One staff member said, "Training is good, I get offered extra training in areas such as dementia." A senior care assistant said that they were happy with the level of training they had received but were worried about the recent changes as the service no longer employed its own trainer on site due to staffing restructures. They stated that they had received further training in the form of National Vocational Qualifications and dementia awareness. They also told us that a colleague had attended a care practitioner's course to enhance their knowledge and responsibility.

The provider had an induction process which encompassed the new Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the certificate. Staff were further supported with progressive supervisions and observations through the initial stages of their employment. These were done to ensure the new staff member understood their role and were competent at providing care.

We spoke with a nurse who had recently been employed. They described how they had received two weeks corporate induction training before transferring to the service. They were designated as supernumerary staff for the next four weeks during which they were mentored by senior registered nurses. They said, "I had enough support, particularly the shadowing, that was good." They described the care assistants as, "Well trained" and said that they were grateful for the support they had received as a new member of staff.

Requires Improvement

Is the service caring?

Our findings

The feedback we received from people and their relatives about care provision during our inspection was positive. In general, we observed positive interactions between people and staff. However, on a small number of occasions this was not consistent. Comments we received from people included, "Staff are caring, some more than others, mainly the older ones, they understand me. I like the way I am being cared for, they know what to do and the way I like things done." Another comment was, "Staff are lovely to me, I like them all, I am happy with the way they do things, I think they all deserve medals." A further person told us, "They are very, very nice and kind." A person's relative said, "They are very caring, they are lovely to my loved one."

We received some less positive feedback about the care that people received. There was however a common theme to this that was centred around staffing. For example, one comment we received was, "Staff are short of time and do not give me enough time to say what I want from them." Another person told us, "The workers come in and wash and dress me, but I do not see much of them otherwise and cannot be made a fuss of, they do not have time to sit and chat because they are understaffed." Another said, "Staff are lovely, it would be nice if they had time to chat but they are busy, they help me."

All of the people we spoke with told us they were treated with dignity and respect. One person said, "Most of the time my door is open but when having personal care it is closed, because people tend to peer in and I do not want the world and his wife to see me." Another said, "They asked me if I object to having a carer of opposite gender and I said no." We observed staff knocking on doors and waiting for people to confirm they could enter. Staff closed bedroom doors when supporting people with personal care and also placed a sign on the person's door indicating personal care was in progress to reduce the risk of another person entering during this time.

Staff knew the people they were caring for. During discussions, staff demonstrated that they understood people's care needs as well as their preferences and personal life histories. They knew what person centred care was and described how they ensured that people's choices were met. For example, one member of staff said, "We should not assume that all people like the same thing. We need to make sure that we do for them exactly what they want, fulfil their personal needs and make sure they still get choices about things."

Generally we observed some positive interactions between staff and people using the service. The atmosphere was calm and friendly and we saw that the majority of staff stopped to speak to people as they passed through different areas of the building. People responded positively when staff approached them. On one occasion we observed one person return to the dining area after being outside. A member of staff opened the door for the person and helped them back inside. They said, "Oh, look your hair is a bit messy from the wind, shall I give it a brush for you?" Another member of staff sat with people and asked them how their day had been.

We observed a member of staff enter the dining room with a person they said, "Where would you like to sit? The person responded by pointing and saying, "Over there." The member of staff checked this was what they

wanted as they would be on their own by asking, "Would you prefer to sit with other people?" The person's decision to sit alone was respected. We saw that staff members came down to people's level and explained things in several different ways. Staff were patient and listened. We saw that people responded in their preferred method of communication. Where people had sensory impairments, this was considered and staff members raised the volume of their voice or showed people in a different format. For example, we saw a staff member show a person a menu and read through the options with them.

We observed how staff engaged positively with people over a mealtime in Salisbury Rise. We observed a staff member engaged a person in a conversation by asking about their recent visitors. The person enjoyed telling the staff member about the visit and who they had seen. We saw that staff members checked that people liked their meal. One staff member asked a person, "Are you enjoying that." A member of staff asked and showed people the drink choices that were available and waited whilst people decided. A member of staff asked one person, "Would you like me to help you cut it up." The person replied, "Yes please." When a person started singing staff joined in. The person smiled and enjoyed this. Afterwards staff discussed the song with the person and they recalled other songs they liked.

In contrast, in the same area of the service we observed interactions between people and staff members that were not so positive. One staff member said, "Put her over there if she has finished," after a person had finished eating their meal. They did not consult the person as to if this was what they wanted. We observed a person saying something to staff. A member of staff said, "Can you speak properly, we cannot understand you when you speak like that." They then left the room without taking the time to find out what the person had said. Another member of staff then sat with the person and asked what the problem was and took the time to engage with the person. The first staff member returned and said, "I couldn't understand her," and then both staff members left the person. The person had not been able to tell anyone what the problem was. We observed people asked questions, without getting an answer from a staff member. For example we observed a person who asked several times what day it was without getting a response from staff.

We observed interactions in Beech Walk over the lunch period. In general, staff interactions with people were positive, however the delivery of fully personalised care was hindered due to staffing numbers. For example, within Beech Walk dining area over the lunch period there was one staff member in the servery plating meals, one care staff member supporting people in the main dining area and a member of the activities team was supporting someone with their meal. Interactions were positive, with the staff asking questions such as, "Are you ready" and "Would you like to try a piece of tomato?" However, at one point another person required support to cut their food. This resulted in the staff member having to leave the person they were supporting, who was unable to hold their meal or cutlery. This took the staff member just over one and a half minutes to do. During this time, the person the staff member was originally supporting was looking at their meal.

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection several visitors came to the service to see people and there was a busy social atmosphere in the communal areas and people's bedrooms. It was clear that staff knew the visitors well when we heard them speaking with them.

There were advanced care plans in place. These are plans that detail people's preferences and choices in relation to whether they want to be admitted to hospital for active treatment, and any decisions they might have made about their end of life care. For example, in some of the plans we saw it had been documented that people only wanted to go to hospital if they broke a bone, otherwise they preferred to remain at Bloomfield. Despite this, we saw that one person had recently been admitted to hospital as an emergency

despite it being documented in their advanced plan, "If ill, stay at home".

The hospital had seen that this was documented and the person was discharged and transported back to the home. It was unclear why the decision to call an ambulance had been reached which contradicted the advance care plan. In addition, this also meant the person underwent unnecessary disruption to their routine. We spoke with the management of the service who told us this decision to convey the person to hospital had been made by the attending paramedics and not the staff at the service. They told us this unnecessary admission had since been reviewed to avoid repetition and this was confirmed by the person's GP.

We saw within one person's record they were nearing the end of their life. Their wishes had been clearly recorded, and stated that they wished to remain in the service. They had been regularly visited by their GP. The person appeared comfortable and their personal hygiene needs met. Regular mouth care was recorded and sips of water given. The person was being repositioned in order to prevent skin pressure damage. The person was in receipt of pain receiving medicines.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of Bloomfield in August 2016, we found that people were not fully protected against the risk of unsafe or inappropriate treatment as records were not accurately maintained. This matter had not been suitably addressed following our inspection in March 2015. Due to the continuing breach of this regulation, we served a Warning Notice. The provider wrote to us in October 2016 to tell us how they would achieve compliance with this regulation. During this inspection, we found that although improvements had been made, records we reviewed were still inaccurate and exposing people to the risk of unsafe or inappropriate care and treatment.

In addition to this, at the last inspection we found that the service did not consistently deliver appropriate care that met people's needs. For example, there was no system in place to regularly check the safety of people in communal areas. Where people had an air mattress to support them with lowering the risk of developing a pressure ulcer, these were not always set at the required level. This placed them at risk and people's individual needs in relation to pain management were not consistently met. The provider wrote to us in September 2016 to tell us how they would achieve compliance with this regulation. During this inspection, we found some improvements had been made, however people were not fully protected from risks associated from the staff recording inaccuracies associated with their care and treatment. It was not evident people had always received care in accordance with their assessed needs.

There were records in place for staff to sign to indicate they had checked that air mattresses were set at the correct pressure. However, these charts were not always completed correctly. Although the majority of the charts we looked at had the correct setting documented, one chart showed that staff had incorrectly signed one chart for at least the 49 days prior to our inspection to confirm the mattress was set to the correct weight. The mattress was set to '40' and staff had signed each day to confirm this. The care plan informed staff the mattress should be set at '30.' We checked the air mattress pump where the instructions were which said, 'up to 55kg – set at 30.' The person's last recorded weight was 52.2kg which mean a setting of 30 was correct. In addition, the person's weight charts showed that their weight had not been above 55kgs since September 2016. This meant that despite mattress checks taking place, there was no apparent measure or system in place to ensure the detail that staff were checking was correct. We showed a nurse the mattress in question and they immediately changed it to the correct setting of 30.

In another person's plan it was documented that they had been admitted to the service from hospital with two pressure ulcers. The associated wound care plans were detailed and the plan in place to prevent further deterioration stated that the person should have their position changed two to four hourly. However, the reposition records in place showed that although this had happened for the two previous days, on 18/03/2017, according to the records, the person had remained in the same position for six hours and had not been repositioned in accordance with their assessed needs. This placed the person at risk of their pressure sore condition deteriorating.

A further record we reviewed showed one person's risk assessment relating to tissue viability. It indicated that they were at high risk of developing pressure sores. They were being cared for in bed. The care plan

developed from the risk assessment lacked detail in relation to how often the person required to be repositioned in order to prevent the risk of pressure ulcers developing. The person had been supplied with a pressure relief air mattress, but no details had been recorded about the mattress or the appropriate inflation setting required. The care plan stated that the person required a different type of mattress, although this type would have been unsuitable given the level of risk indicated by the risk assessment.

We asked a member of care staff about how often the person needed to have their position changed whilst in bed. They said, "About three hourly as his skin is good at the moment." They stated that the person was sometimes able to move themselves. We looked at records kept in the person's room. These detailed staff interventions for repositioning the person. We reviewed the repositioning records for the 19/03/2017 through to 20/03/2017. These recorded that the person was being repositioned inconsistently, with periods of three, four and five hours between repositioning. This indicated the lack of detail in the person's record was having a negative effect on their care provision.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although care plans detailed people's needs and guided staff on how to meet those needs, some of the plans contained contradictory guidance. In addition, some of the records that staff completed to demonstrate they had provided the care as planned did not show that staff knew or understood how the records linked with the care plans.

In one care plan we looked at, within the mobility section it had been documented the person's position should be changed, '3-4 hourly' and yet in the tissue viability section of their care records it was documented that their position should be changed, '2-3 hourly.' Alongside this, 'Reposition charts' that were in place for some people did not always reflect the care plan guidance. For example, in one person's plan it had been documented that they were a high risk of pressure ulcers and should be repositioned, '2-4 hourly'. However, the charts that staff had completed did not reflect this. The charts for the previous two days showed that the person had been, 'assisted out of bed' between 8.00am and 8.30am and had been, 'assisted into bed' at 6.40pm and 7.05pm. There was nothing documented on either day to indicate that the person had changed position during the ten hour period they were out of bed. We discussed this with some members of staff who told us the person did have their position changed but that it hadn't been documented in their records.

Other examples of poor record keeping in relation to pressure ulcer care were observed. For example, one person's plan stated that they were provided with a 'Triflex' pressure relief mattress but they were found to have a 'Talley Fusion' air mattress in place. Another person's plan stated that they required an air mattress as they had acquired a pressure ulcer whilst in hospital. The plan said that the person required '2-3 hourly repositioning.' Upon visiting the person's room, there was no air mattress on the bed and records of positional changes indicated repositioning between 3 -5 hourly during the night. We spoke with staff who informed us that the person's pressure sore had healed and that they were now up in their wheelchair. This meant that the information in the care plan was inaccurate.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt staff responded to their needs. We received some positive comments from people and their relatives. One person said, "Staff are very good in the way they treat me and have got a very good attitude, the older ones are the most caring." Another person said, "They are always kind to me." We asked people about their care records. One person we spoke with about their records said, "I have a care

plan in my room, I never read it, we have a care review regularly and I am able to say what I think. I make all my own decisions and am independent. Staff understand me and do things as I like, we have a laugh. If I had any complaints or concerns I would soon say so."

Care plans were generally person centred. Where able to, people had signed to indicate they agreed with their plan of care. The plans were reviewed monthly. However, we found that whilst individual care plans were regularly reviewed, an overall review of people's care which was meant to happen every six months was not consistently occurring. The care profile review form stated, 'The profile is to be formally reviewed every six months or more frequently if required with the individual/or their relative or advocate including medication review.' Of the care plans we reviewed, we saw that whilst the majority had undergone a six month review, some had not.

Care records showed people's usual routines. This enabled staff to offer care and support in the way that people wished. In one person's care record it said, 'Likes to stay in bed and get up when she is ready.' This ensured that staff did not go and wake the person before they were ready. Other care records described people's personal preferences. For example one record stated, 'Likes toast and marmalade and coffee with sugar and no milk.' We saw that people's religious and cultural preferences were described and what this meant for a person for example, particular food choices. This detail was consistent within records. For example, in one person's sleep plan, their preferred night attire was listed, their preference for having the window slightly open and a bedside light on. One person's record showed, 'Likes classical music.' When we checked, this person was in bed and their radio was playing classical music in accordance with the plan.

There was a section in the care record to describe people's life history. This described people's interests, past employment and significant events in their life. We found that this section was inconsistently completed in the care records we reviewed. In some records there was lots of information and detail. For example, we saw in one record a person lived in Cornwall, their career as a teacher was described and all the names of their grandchildren listed. However, in other care records we reviewed this section was partially completed or not completed at all. This meant that in some care records there was little personal information, this can impact on people as staff are then not aware of areas of significance and importance to that person.

Care records described how people preferred to communicate. One care record that we reviewed said, 'Uses her body language to communicate.' Care records gave directions to staff on how to maintain people's privacy and dignity. For example, one care record said, 'Staff will ensure that [Name of person] dignity is safeguarded by closing her door and curtains.' Some people had plans in place for when they displayed signs of anxiety or agitation. These plans were generally very detailed and provided suggested methods for staff to follow in order to relieve any agitation. For example, in one plan the guidance was, 'Talk about his wife', 'Leave alone for 10 minutes' and 'Try another member of staff to provide assistance.' However, additional detail about any known triggers for what might cause the person to become agitated could also be documented to aid staff.

The service had received eight complaints since September 2016. We saw that complaints were fully investigated and responded to. Where possible, the registered manager had met with the person making the complaint to discuss and resolve the issues raised. Actions were taken in response to any complaints made and these were communicated to the complainant. Where an apology was needed this was given and shortfalls by the service acknowledged. It was noted that a theme associated with the complaints related to staffing levels at the service.

Activities at Bloomfield were provided seven days a week, with three activities daily. There was a timetable

in the foyer about the activities available. Activities available included a current Mother's Day and Red Nose Day celebration with tea, cakes and a singer. Other activities included a daily manicure, karaoke, jigsaw puzzles, bingo and pottery. After lunch we saw that people were asked if they wished to attend the pottery session. On the day of our inspection we observed an activity session involving school children from the local primary school as part of the 'Paint Pals Project' organised by ALIVE! 10 residents and seven children from the school participated. All involved appeared to be enjoying the session, which was facilitated by the activities co-ordinating staff.

There were also links with the local community. The service had volunteers who were people's relatives. One drove the mini-bus to allow people to access the local area and allowed some people to attend the 'Stroke Club' every week. Another volunteer attended the service weekly to play the organ for the 'Songs of Praise' and this person also assisted at bingo. A number of people from the local churches attended Bloomfield to give a service to people, with some giving a 'One to One' service and others delivered the service to a group. The local library visited the service regularly to ensure a good supply of books was available. At Christmas time the service had the local schools in for concerts, as well as local bell ringers and local choirs.

Inadequate

Is the service well-led?

Our findings

At the inspection of Bloomfield in August 2016, we found that the provider had not ensured clinical governance systems were used effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This matter had not been suitably addressed following our inspection in March 2015. Due to the continuing breach of this regulation, we served a Warning Notice. The provider wrote to us in October 2016 to tell us how they would achieve compliance with this regulation. During this inspection, we found that although improvements had been made, governance systems were still not fully effective.

In addition, at the last inspection we found that a notification the service was required to send us by law had not been sent. The provider wrote to us in September 2016 to tell us how they would achieve compliance with this regulation. During a review of the notifications sent, we found that although we had received most notifications as required, a serious injury notification had not been received. It was found that in February 2017, a person had fallen within the service. Shortly after this and following the involvement of other healthcare professionals, the person was diagnosed with a fracture. The service had not sent the legal notification as required.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Although we found some improvements in relation to governance systems and the effective management of medicines, it was evident that there were still no effective governance systems that monitored the completion and accuracy of people's care records. The current auditing systems were not robust and these audits did not have the detail or depth to identify the shortfalls in relation to record keeping or care planning we identified during the inspection. For example, as reported in the 'Responsive' section of this report, audits had failed to identify that there was conflicting information within people's care records relating to their pressure ulcer care. In addition to this, staff we spoke with told us that although they had given care in line with people's assessed needs this had not been recorded. There was no effective system to capture these recording omissions.

Although there were systems that reviewed if records were held, it was not evident these were effectively monitoring the contents and accuracy of the records. For example, an effective governance system would have identified that a person's wound care management plan contained no detail relating to the inflation setting requirements of the mattress in place to reduce the risk of developing a pressure ulcer. An effective audit would ensure inaccurate records or records that did not show a person's current needs were identified. For example, the record we reviewed showing a person required an air mattress and repositioning as they had a pressure ulcer that was identified as incorrect. We established through staff that the person's pressure sore had healed and that they were now in their wheelchair. No new care records had been created to reflect the person's current needs and this would be identified through effective governance.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The feedback we received from some people at the service was not consistently positive. Some people we spoke with told us they were not aware of who the management were in Bloomfield. One person we spoke with said, "I would not know them if they walked into my room." However, other people we spoke with told us, "I know the managers, they call out in passing, or pop in to see my garden from the window." We spoke with people about meetings and involvement at the service. Two people we spoke with told us they no longer went to residents' meetings. One said, "I used to go, but with all the changes of managers, nothing is ever done, they do not listen and do what we ask." We also asked people about the leadership at the service. One commented, "The local managers (at Bloomfield) are alright but the family have had problems with top management (provider's senior management) and following a recent meeting we have lodged a complaint."

People and their relatives had the opportunity to attend meetings to find out key information about the service and contribute their thoughts. We reviewed the meeting minutes for the last meeting and saw that matters such as staffing appointments, meal preferences, laundry and new appointments with the provider's senior staffing team were communicated. People we spoke with told us they were aware that meetings were held and some said they attended. However, as detailed above, we also received some negative feedback about how effective people felt the meetings were.

Staff we spoke with gave mixed feedback about the management and leadership at the service, but the feedback was mostly positive. Some staff we spoke with commented on the different accommodation areas of the service. One said the areas were, "Very separate" and told us, "Staff tend to stick to their unit." A staff member, when asked about communication, told us, "(We are) not always told things that are going on." They gave an example relating to the last inspection at the service when they were congratulated on getting 'Good' in the 'Caring' domain. They said the less positive things highlighted within the report weren't explained or told what was going to change to get better.

Some of the staff we spoke with told us they felt they had limited contact with the registered manager and deputy manager. This had resulted in some staff telling us they wouldn't go to either of them to discuss matters unless it was totally necessary. They told us they would initially speak with a nurse if they had any concerns or issues. Another member of staff told us that at times, if they approached the management to raise a concern (an example given was of short notice unplanned staff sickness) they felt they received a, 'Just deal with it' style response and did not always receive support. In contrast, other staff spoke positively of the management. One told us the management were, "Very good to work for." Another comment was that the management were, "Very understanding."

There were systems to communicate with staff. The service management held daily meetings with heads of departments to ensure key messages were communicated. These ensured issues such as current occupancy, staffing levels and any scheduled discharges from the service were communicated. Periodic meetings were held for all general staff and registered nurses. The supporting minutes showed matters such as record keeping, staffing cover, care planning, infection control and moving and handling were discussed at general staff meetings. Registered nurse meetings discussed clinical matters within the service and people's individual care needs.

Governance systems in place monitored people's health and welfare. The deputy manager had governance systems that included a monthly care profile review to ensure care plans were in place. There was a daily care report that ensured daily reports such as the staffing assessment tool, accidents and incidents, food and fluid charts and 'Resident of the Day' records were completed. There was a documentation audit that monitored if care plans were completed correctly. Some of these documentation audits had been effective

in identifying shortfalls such as information not being current and additional detail being required. However, as detailed above the audit had not identified the recording errors we found during the inspection.

There were clinical governance auditing systems in place that reviewed matters such as infection control, hospital admissions, tissue viability and nutrition, together with an overview of the legal notifications sent to the Care Quality Commission. Clinical governance meetings were also held between senior managers and nurses. There were additional audits completed in relation to health and safety aspects of the service that monitored risk assessments, fire testing, training and first aid equipment checks. Audits and monitoring were also completed in relation to housekeeping and cleanliness. As evidenced in the 'Safe' domain of this report, effective medicines audits were also completed.

The service had a 'Resident of the Day' scheme in operation to ensure people were happy with various different aspects of their care and support. The nominated 'Resident of the Day' would be visited by various different departments throughout the service. For example, somebody from maintenance would visit to ensure people were happy with their room and a chef would visit to ensure people were happy with the meals provided. A member of the activities staff would ensure people were satisfied with activities and housekeeping staff would ensure the person's room was at a cleanliness standard that was satisfactory. The person would also be visited by care staff and a nurse to ensure their care and support needs were met. We saw from records that this had resulted in care records and preferences being updated.

The service received support from the provider. We saw that the service received regular support from the clinical support team. This support included the production of a clinical action plan which was periodically reviewed. In addition to this, clinical governance auditing results were also sent to a senior regional figure for evaluation and review. A 'Quality First' audit had been completed in March 2017 which was based on the key questions asked by the Care Quality Commission during an inspection. This audit had been completed by a senior member of the provider's management team who was not employed at the service. We saw that this had identified areas for improvement in relation to the completion of supervision and appraisal meetings and the completion of certain care records. This audit did not however identify the record keeping shortfalls identified during the inspection.