St Anne's Community Services

St Anne's Community Services - Queensway

Inspection report

46 Queensway
Kirkburton.
Huddersfield. HD8 0SR.
Tel: 01484 602523
Website: www.stannes.org.uk

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Ratings

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

Overall summary

The inspection of Queensway took place on 5 May 2015 and was unannounced. We previously inspected the service in December 2013 and found the service to be meeting the regulations we checked at that time.

Queensway is a care home with nursing. The home can accommodate up to six people aged between 18 and 65 with complex cognitive disabilities and verbal communication difficulties. It consists of living and communal accommodation over two floors and has an enclosed garden.

People were safe and staff were providing support when needed and had a sound understanding of what constituted a safeguarding concern. It was evident throughout the day of our inspection that staff knew the people well, and responded to their specific needs.

Summary of findings

We found that medicines management was problematic as stock levels did not always tally, and there had been no action on securing replacement medicines for people after a medicine cupboard lock had broken which prevented access to these medicines.

The service had adequate staffing levels on the day of our inspection but we found there was a reliance on agency staff, particularly for nurses. This meant that permanent staff were having to spend considerable time with the agency staff explaining people's needs and also that the people living at Queensway with complex needs were having to get to know lots of different people which lacked continuity for people and could become unsettling for them.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The service demonstrated knowledge of the importance of seeking consent and ensuring they were acting in people's best interests. This was appropriately documented and observations throughout the day further evidenced this embedded practice.

Staff were caring and had positive relationships with people in the home. It was evident permanent staff knew people well and were able to have a good rapport with people. The atmosphere was relaxed throughout the day and people's wishes were always respected, whether this was in food choice, activity or in receiving personal care support. It was evident that the home belonged to the people living there as the days were shaped by their preferences. Staff were clearly there to support and guide people with gentle prompts, always allowing them to make their own decisions.

There was a registered manager who had been registered since November 2014. 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. They were only on site two days a week so there was a heavy reliance on the deputy manager. It was clear the home was well managed as it was calm and welcoming, and people were settled.

While we saw evidence of effective systems in place for picking up issues for individuals within the home, such as when they needed increased support due to health concerns, we saw little service-wide monitoring of how the home was ensuring quality.

You can see what action we 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?

Requires improvement

The service was not always safe.

People seemed happy and settled and we found staff had a detailed understanding of safeguarding procedures.

Medicines were administered safely but stock control was poor. We found discrepancies in audits and also inaction in securing replacement medicines for people when the lock had broken on the medicines cupboard which prevented access to these medicines.

Staffing was adequate but there was regular use of agency staff as the service acknowledged they had difficulties in recruiting.

Is the service effective?

Requires improvement

The service was not always effective.

People were being cared for by well supported staff. However, support staff had not had access to training on DoLS and this meant that people may not have been cared in accordance with these specific requirements.

The home had a good understanding of how to obtain consent and the importance of recording this appropriately. They supported people to make as many choices as possible themselves, promoting independence.

There was evidence of extensive multi-disciplinary involvement in planning people's care and ensuring their needs were met.

Is the service caring?

Good

The service was caring.

Staff displayed some excellent attitudes and had infinite patience. They were supportive of people, ensuring they were happy and acknowledged when seeking attention but also left alone when they signified this.

The atmosphere was relaxed and positive in the home all day, and this was reflected in the affection people were shown.

People were enabled to be as independent as possible, especially with personal care and support was always available and never rushed.

Is the service responsive?

Good

The service was responsive.

People were cared for in a way which reflected their own preferences and responded to their different levels of abilities.

There were numerous activities for people to join in and people were able to choose what they participated in.

Summary of findings

The service had received no complaints but were always learning from training undertaken as to how they could improve their service.

Is the service well-led?

Requires improvement

The service was not always well led.

The atmosphere in the service was positive and led by the needs of the people living there.

Staff tried to empower people as much as possible.

The service was well supported by the deputy manager as the registered manager was only on site for two days a week. There was limited evidence of service-wide audits as monitoring tended to be completed for people using the service rather than looking at overall service provision.

St Anne's Community Services - Queensway

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.

The inspection took place on 5 May 2015 and was unannounced. The inspection team comprised of three adult social care inspectors.

Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

People at the home were not always able to verbalise their opinion and so we spent much of our time observing interactions between staff and people. It was not possible to use a SOFI as people were very mobile and it would have distressed some people to be observed continuously. The Short Observational Framework for Inspection is a tool we sometimes use to help understand the experience of people who could not initiate conversation with us.

We observed all people who used the service throughout the day but due to the difficulties in communication verbal feedback was minimal. We interviewed five members of staff including support staff, nurses, the deputy manager and the registered manager.

We looked at four care records and three personnel files. We also reviewed quality audits including medication, maintenance records, accident and incident logs and risk assessments.

Requires improvement

Is the service safe?

Our findings

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. Medicines were stored within locked cupboards in the registered manager's office. Within the folder containing Medication Administration Record (MAR) sheets, we found guidance for staff administering medicines and for the supervision of student nurses administering medicines. The folder also contained instructions for what staff should do if they made an administration error and a list of staff signatures.

With each person's MAR sheet there was a photograph of the individual, their name, date of birth, any allergies and clear information about how the person preferred to take their medicine. This included how the person demonstrated their consent to taking the medicine.

We observed some medicines being administered and noted that staff followed good practice in that they recorded a dot on the MAR when they took the medicine to the individual and signed it as taken when they returned.

We saw the MAR sheets in place were produced by staff at the home rather than being supplied by the pharmacy. Staff told us this was a very time consuming task as each medicine had to be listed along with an explanation what they were used for and guidelines for any PRN (as required) medicines. The MAR sheet clearly showed the name of the medicine, the dose to be taken, the route (for example 'oral') and the frequency at which the medicine should be taken. Staff explained that these MAR charts had been introduced in response to previous medication errors at the home. After each administration, the nurse had to record the running stock check of the medicine.

We checked a sample of individual medicines and found that the stock check recorded was accurate.

However, when we tried to check one person's PRN paracetemol stock, we found it had not always tallied. The explanation written on the sheet for this was "believed to have been taken from stock." This indicated that, rather than the person having their own prescribed paracetamol, staff had used a stock supply. When we checked the 'stock' paracetamol record, there was no record of that medicine being given to the person concerned. We were further concerned that the stock paracetamol record tallied despite no record of the tablets having been taken on two separate occasions. This indicated that accurate medicine counts were not being undertaken.

We saw that some people were prescribed medicines such as creams for irritated or broken skin, enemas and haemorrhoid treatments. These were kept in a small cupboard separate to the other medicines. When we looked at two people's stock check sheet for these medicines we saw staff had recorded 'Unable to access cabinet, lock faulty.' This had been recorded on 10 occasions dating back to January 2015, evidenced in the maintenance log. This meant that the staff had not been able to access these medicines for several months and therefore some people may have been denied their prescribed medicines.

We found the lock on the cupboard on the day of our inspection was still faulty although the manager told us a new cupboard was waiting to be fitted. We asked the registered manager if replacement medicines had been requested in the interim pending the replacement of the medicine cabinet but we were told they had not. We judged this to have had a minor impact on people using the service as the medication was not for daily use but it could have affected the wellbeing of an individual using the service due to the time they were not in receipt of it.

We saw several empty medicine boxes had been thrown in the general waste bin. Although staff had scored through the individual's name, it was still clearly visible.

This is a breach of Regulation 12(f) and (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as although the systems were in place to administer medicines and staff were following these, there was poor stock control and inaction on securing replacement medicine that had become locked in the broken cupboard.

Staff told us they had been understaffed for approximately a year. Whilst there should have been fifteen staff there were currently only twelve. We discussed the staffing concerns with the registered manager who acknowledged there was a problem, but said the home had experienced difficulties with recruitment. This persistent understaffing increased the workload for permanent staff as they were regularly having to spend time introducing people and explaining people's needs. The use of agency staffing for

Is the service safe?

this group of vulnerable people with complex cognitive and communication problems was of particular concern when minor changes in staffing could be unsettling and disruptive to usual routines.

The staffing shortage was also reflected in supervision records and staff's discussions around low morale. The concerns expressed focused on the service having had three different managers in a short space of time and the use of agency staff as this required more input from the regular staff to ensure continuity for the people at Queensway.

We asked the registered manager about staffing rotas and were advised that each shift had a nurse and two support workers on duty. There was also a sleep-in and waking member of staff overnight. The registered manager was aware there was a shortage of qualified staff. They told us that a nurse had been recruited but they were not able to start until September.

We also asked how the registered manager how they covered sick leave and were told that current staff were asked but usually it results in agency staff. This could be unsettling for the people using the service.

The staff we spoke with told us they had received training in safeguarding and that they knew about the whistleblowing policy. They were confident that people at Queensway were safe because staff could understand and could interpret peoples' specific needs. The student nurse on placement was also confident that people who lived at this home were safe from abuse and told us they were familiar with the process of raising a concern.

We asked the registered manager their understanding about what action should be taken in the event of a safeguarding concern. They were able to relay the process of alerting the relevant authorities, and how to support people living at Queensway through the experience. They were also clear with regard to their understanding of how to support staff if necessary, and how to improve performance. They were keen to ensure all staff had access to learning from such events if the situation arose and would do this through a staff meeting.

We observed the induction of a new agency staff member. They were given a comprehensive induction of the building including fire exits, information about people in the service and where to find and use the daily records. This demonstrated that staff were receiving appropriate support to the service but also emphasised how much time was being spent by regular staff having to undertake this role.

We saw evidence in the care plans that individual risks relating to people who use the service were assessed. For example, behaviours, travelling by car, road safety and eating disorders. When we accompanied people on a visit to a local community facility we saw how people's safety risks were managed. They were supported to travel comfortably and safely, and then walk in public places at their own pace without being over protected. This was done by allowing people a high degree of freedom to walk unaided whilst at the same time gently encouraging them and giving direction to the activity rather than any form of control.

We found appropriate personal emergency evacuation plans for people who lived at the home. Staff told us that they had received training in fire evacuation and that fire alarms were tested weekly. The fire evacuation procedure was on the wall. Accidents and incidents were recorded in an appropriate manner detailing the event and the resulting action.

On the day of our inspection the home was clean and there were no discernible odours. Staff told us people had sufficient personal supplies in order to undertake their personal care safely. They told us that people had their own baskets containing their own personal effects for when they were receiving personal care. We also saw personal protection equipment being used during the day, and noted that there were sufficient hand washing equipment for staff use in the communal areas.

There was a detailed infection control statement outlining the cleaning schedule including for all communal areas and containing sheets to be signed upon completion. There were pictures up around the home reminding people to wash their hands and also different colour-coded mops and buckets for cleaning different areas of the home. Our only observation regarding infection control was that the water took some time to get warm but we were advised this was due to the inefficient boiler, and that the temperature was also closely monitored as some people were unable to distinguish hot and cold.

Requires improvement

Is the service effective?

Our findings

Staff told us they received regular supervision during which they discussed their key worker responsibilities and ensured they could undertake their roles safely. They told us they had all had an annual appraisal. We looked at staff files and saw staff had completed an appropriate induction which included mandatory training and also checked how much knowledge staff had gained about the people within the service by reading through their support plans.

We found there were records of supervision and discussions around staff performance. In one file we saw it had been identified that one member of staff had not booked on the renewals for training that had expired. It had been emphasised by their line manager that this was not optional and that it needed to be booked. A deadline had been given. Another file evidenced external support was offered to a staff member who was facing some difficulties.

Supervision records demonstrated achievements as well as challenges. They reflected the level of understanding a staff member had and tried to reflect their learning needs. The files also contained semi-completed appraisals which had objectives.

The staff we spoke with had both professional qualifications and nationally recognised university qualifications in care. The nurses were appropriately registered and qualified mentors for student nurses on placement. Staff also told us they had received mandatory updates to enable them to effectively carry out their responsibilities. Staff had also received additional training in managing positive behaviours and diversity training.

Staff training was evidenced in the comprehensive training matrix with the date courses had been completed and the expiry date of specific training. It was a personal record for each member of staff enabling easy identification where training needed updating. Work was ongoing in addressing where training had expired and bookings requested for the required courses.

We saw staff had received training in positive behaviour support training as a means of defusing potentially difficult situations. It was also clear that staff had a good understanding of treating people with dignity and respect as the conduct we observed throughout the day was extremely positive.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The nurses told us they had received training in Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act although support workers had not. When the nurses were asked they could explain its implications for the people who lived at the home. The registered manager was also aware that only qualified staff had access to DoLS training and that the support staff should have equal support in this. They were actively seeking this training from the provider.

We noted that in the care plans we reviewed that there were a number of restrictions imposed on peoples' freedom within the home. For example, locked doors and cupboards or in using the bathroom on their own. In addition, we saw that people also had their movements closely monitored by staff throughout the day. The deputy manager and registered manager had not considered if this constituted a deprivation of their liberties. We discussed this and the registered manager told us they would consider if a DoLS application would be required.

The registered manager demonstrated a good understanding of the importance of following the Code of Practice for the Mental Capacity Act 2005. They told us how one person had had to have a series of best interest meetings to ensure they received the medical help they required. This was evidenced in the person's file. The registered manager was fully aware of the importance of engaging with the person's advocate and Independent Mental Capacity Advocate (IMCA) whose role was to ensure they represented the person's wishes as far as possible. This person was subject to a DoLS for a period of six months as they required 1-to-1 monitoring. All appropriate assessments had been undertaken.

It had been identified following some recent reviews with health professionals that as some people were unaware of the risk of hot water or hot surfaces (e.g. the oven door) that the kitchen doors be locked while in use for cooking. This would severely restrict people's freedom within the home to access the back garden as access was via the

Requires improvement

Is the service effective?

kitchen, and people tended to walk through the kitchen to access the dining room from the lounge. The registered manager was aware they may need to consider a DoLS application for each person.

We inspected the kitchens, and saw that they were well maintained and that appropriate records and checks were maintained to ensure safe preparation and handling of food. Staff told us that they had received food handling training as part of their mandatory updates, and this was evidenced in the training records. Food was freshly prepared in the home by support staff with help from people using the service when they wished.

We saw evidence in the care plans we reviewed that people had their nutritional status assessed, were weighed monthly and had their plans reviewed. We also told how people had their care implemented. We were told how one person was encouraged to eat extra food during the day to compensate for their over activity, and observed another person being encouraged to exercise in order to help with their weight reduction.

During the day we also saw how people were empowered and supported by care staff to make their choice of food and drink known. For example, staff could explain how they observed people's behaviour towards the foods they were offered. We saw in the daily communication logs that people's food preferences were responded to. One person had asked for baked beans with their meal and this was duly provided.

It was clear from the care records that input from appropriate health professionals were requested when required. There was evidence of support being requested appropriately and in a timely manner, especially in one instance where a person had been in considerable pain. This had only been detected because of the staff's in-depth knowledge of the person.

There was one bathroom with a bath upstairs and a shower room downstairs with a wall-mounted seat. There was also a separate laundry suitably equipped. All individual rooms were personalised with photographs and name badges. There was a deep step to the outside garden and the threshold against the kitchen door needed some attention. This was identified in the maintenance records. The garden at the back was enclosed with outdoor seating. There was also an adapted garden at the front with a swing so that people could sit outside in better weather. This was accessed through patio doors from the dining room.

Good

Is the service caring?

Our findings

People were happy and relaxed despite our presence which we acknowledged was unsettling. One person was particularly keen to show us their musical skills and they were encouraged to do this by staff. They played the piano and staff sought to engage with them by explaining and checking with them the importance of music to them. The atmosphere remained relaxed throughout the day and people were supported to become involved in what they wished.

Most staff told us they enjoyed their work, and said it was "great" or "nice" as the people they looked after were lovely. Another said they "quite liked it".

We observed staff to be helpful, polite and sensitive in their dealings with people through the day. We also heard a number of mutual friendly exchanges between the people who lived at the home and staff, as well as between the staff.

Peoples' dignity was respected. For example, we saw how they dealt sensitively with a person who could only make physical gestures when they needed help with personal care whilst in a public place. We accompanied people on a visit to a local community facilities and saw how they were supported to exercise their rights as a paying customer whilst on this visit.

Staff supported someone have a shower in a calm and sensitive manner. They were encouraged through the shower door to undertake as many tasks themselves as possible.

Although the people who lived at the home were unable to verbalise their needs, they were empowered by staff to communicate their needs and choices throughout the day. They did this using a variety of hand gestures and physical signs which staff then checked that they had interpreted them correctly, before they acted. This demonstrated a respect for opinions of the people who lived at Queensway, and also contributed to ensuring peoples positive behaviours were encouraged and reduced their anxiety levels.

It was evident through the interactions we observed that staff knew people well, and even those who didn't, were keen to take the lead from the more experienced members there.

People were supported to maintain family relationships where possible. Staff helped them to visit when they wished and facilitated visits to family. One person was supported by staff to visit the local town to meet their relatives on a regular basis as this was easier for the relatives to access. Staff also supported people to have short breaks and holidays where possible.

We saw in the care records that people had access to advocacy support on a regular basis to assist in making more complex decisions such as when to have medical treatment. The registered manager also told us an advocate had been supporting someone who had recently had to change rooms in the home to enable their mobility needs to be better met. We observed staff throughout the day ensuring that people were encouraged to make as many decisions for themselves as possible by giving them simple options such as at lunchtime.

Good

Is the service responsive?

Our findings

One of the people was having their breakfast at the dining table after we had toured the building. Staff told us they had been very tired and wanted a lie-in. This showed the service was focusing on individual preferences. Another person did not get up until 10.30am and came downstairs to have their shower. They had the support at the time they needed and there was no suggestion they needed to hurry. They were then offered a choice of breakfast and after being given their choice decided they didn't want it, so they were offered an alternative and ate this instead.

There was a pictorial guide to people's individual responsibilities at mealtimes; one person was responsible for putting mats on the table, another did the cutlery and one loaded the dishwasher. We observed people completing their various tasks later in the day and found it encouraged a shared responsibility in living in the home.

We asked the registered manager about the provision of activities. We were told that one person attended film showings that were specific for people on the autism spectrum. We also saw records that people attended an art group and Gateway, a social club for people with learning disabilities. Where people found it difficult to engage with a specific activity, walks were arranged with support staff to ensure people had the opportunity to experience new environments.

There were also activities within the home that people could join in if they wished such as arts and crafts, the garden and helping to cook meals within the home. In the afternoon most people had congregated in the TV lounge with the staff. People were also able to access their rooms during any part of the day if they preferred to be on their own.

The registered manager also told us that they supported everyone to have a holiday if they wished. One person was keen to go to Exeter Cathedral as they liked the organ and plans were being made to facilitate this. The dining room was decorated with a range of photos of people doing various activities and included some of their more recent holiday photos. There were also pictures of recently made Easter bonnets and people's calendars showing their activities.

We saw that care records were person-centred with photos and details of each individual. They contained important information as to how best communicate with them, things that made them happy or sad and relevant health information including all medicines. There was very specific information for people on how to support them such as when administering medicines or having medical treatment. There was evidence of capacity assessments taken for specific decisions and resulting best interest meetings held with appropriate people such as when they required medical treatment.

The care records comprised of support plans and health action plans. These were reviewed and discussed with the key workers and support staff. Both types of plans demonstrated a high degree of person centred care specifically related to the cognitive disabilities of the people who lived at the home. This demonstrated that the home used and responded to the policy recommendations for health and wellbeing checks specifically related to this group of people. The health records were comprehensive and contained various monitoring charts for both physical and mental health needs.

The home used a key worker system which meant that they had specific responsibility for people within the home. Staff were able to describe the person for whom they had responsibility detailing the person's specific physical, emotional and behavioural needs. This included how they signed to give consent, time they liked to get up or how their clothes had to be fastened in a particular way.

Assessments of people's specific needs and reviews were undertaken by staff. Physical needs such as weight assessment and monitoring was also used for people who needed support to maintain a healthy diet.

We saw the activity rota for the week beginning 20 April 2015 which included daycare, medical appointments, walking, craft group, shopping, church and Gateway. Most people in that week had undertaken three or four of these alongside specific activities within the house. One person liked to attend church and their daily log recorded that they had attended that week. Others preferred to go walking and there were records of these happening on a daily basis with different people. One person attended a local walking group every Tuesday and they attended on the day of our inspection. They were often combined with a social activity such as having refreshments in local cafes.

There was a detailed health action plan developed for someone who needed to increase their daily exercise. It

Good

Is the service responsive?

included details for all staff on how to engage with the person to really encourage them to initiate going out. The person was encouraged to participate by going to coffee shops as they enjoyed this activity rather than just walking with no purpose. There was a record of when and where these walks had taken place showing that staff were responding well to the action plan.

Daily communication logs were kept in the kitchen and completed twice daily. They contained information outlining the tasks people were supported with such as personal care tasks and activities undertaken during the day such as trips out. They also contained details of night time activities such as not being able to sleep and times when people needed reassurance. People's moods were also noted helping staff to identify if there were any concerns to be followed up. They were detailed and were very person-centred. It was evident that staff knew the people well and supported them in the way they preferred.

The registered manager told us that there was a handover at the end of each shift. This involved staff checking the daily notes and identifying any outstanding care tasks. This was led by the shift leader. We observed this happening in the afternoon of our inspection.

We asked the registered manager if they had any complaints or compliments. The registered manager explained that no complaints had been received for the service. Staff were able to respond to someone's needs if they were distressed and no visitor had ever expressed any concerns. One person met family members with staff support in the local town as this was easier for the family to access. Another person visited family further away for a weekend and two staff accompanied them.

Staff told us that any concerns they had could be reported to the manager who they were confident would deal with appropriately with them.

Requires improvement

Is the service well-led?

Our findings

There was an informal, homely atmosphere at Queensway. Staff worked unobtrusively to direct and support people with their activities throughout the day. Staff told us that they worked well as a team and communicated with each other in team meetings and daily handovers. It was evident throughout the day that the home belonged to the people living there and staff were led by them. The whole service was led by what people wanted to do such as having a lazy morning or going out for a walk and any necessary tasks such as cooking dinner were completed in and amongst supporting people living at Queensway.

There was a registered manager in post who had been there since November 2014. However, we were advised they were split between two sites and only spent two days a week at Queensway. This was because the other site had no deputy. There was full time deputy manager in post.

Staff told us the deputy manager was "great", they felt supported and had a good relationship with them. The registered manager felt they had a lot of support from the deputy manager and that they work well together. Again, this was evident throughout the time of our inspection.

The registered manager was keen to ensure all staff had the support they needed. We observed them talking to staff in a positive manner and encouraging them in their daily role. They explained they had implemented a number of changes and felt these had been received positively as they had explained why they were making changes and what the benefits would be. These changes included amending the cleaning schedule which was now much more in-depth and there had been amendments to how staff could request holidays to ensure the needs of the service were met in the first instance. The registered manager told us they hold regular staff meetings to discuss key issues and learning points form any recent events. We did not see any minutes of these.

We asked the registered manager what they felt their key achievements were and they said 'building a team and getting people to work towards the same goals'. One of the biggest sources of evidence of this was the creation of the garden at the front where both staff and people living at Queensway had helped design and plant it. The registered manager was encouraging staff to bring more of their own initiatives for activities for people to undertake.

We saw numerous audits including monthly mattress checks, kitchen, dining room, lounge, laundry and hall and landing which had all been checked in April 2015. The bedrooms had all been checked in January 2015 and there had been one further check for one person in April 2015. This showed the provider was ensuring that equipment was properly maintained and fit for purpose. The home was well cared for and this helped the people living there to feel settled.

We found the maintenance records to be comprehensive but found the work was not carried out in a timely manner. The new medicines cabinet had arrived within the service on 19 February and the maintenance team were advised on the same day but it was still in its box on the floor in the reception area despite numerous calls asking for the work to be completed. There was also a premises safety report completed in April 2015 which again referred to issues previously reported such as the oven setting not working properly (this had originally been reported in January 2015).

While care records were completed in a person-centred manner, there was limited evidence of systems in place for monitoring the quality of provision overall. There were charts in place for individuals regarding difficult behaviour incidents and seizures for example. It was clear that this evidence was acted on through the subsequent recordings in the daily records where staff had sought medical advice as necessary and detailed analysis of where events had occurred to identify possible triggers. Accidents and incidents were recorded appropriately with necessary action taken but there was no further analysis of events for the service overall.

All notifications to ourselves were reported appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicine stock controls did not always correspond with records and there had been inaction in securing replacement medicines for those locked in the cupboard.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.