Chataway Residential Home Limited

Chataway Care Home

Inspection report

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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

We carried out our inspection on 25 August 2015 unannounced and returned, announced on the 26 August 2015

Chataway Care Home is registered to provide residential accommodation for up to 14 people who require personal and nursing care. There were 12 people using the service at the time of our inspection.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager on the day of our inspection. We spoke with the provider who told us that they would support the new manager in applying to become the registered manager following our inspection. We confirmed with the business manager that the process had started.

Summary of findings

People we spoke with and relatives were satisfied with the care and support provided. Some people raised concerns about staffing levels but all said that they felt people were safe. People also said that their individual needs and wishes were known and understood.

We found staff were mostly caring, kind and compassionate in their approach. Occassionally they showed their frustration when speaking with people. They understood people's individual needs.

People we spoke with and relatives told us that they were involved in discussions and decisions about their care and treatment. Additionally, people said they knew how to make a complaint and they would feel confident to do so if required.

Staff received appropriate training and development opportunities to review and develop their practice. Staff recruitment procedures were robust and ensured that appropriate checks were carried out before staff started work.

Concerns were identified that staff did not always have sufficient time to spend with people and develop meaningful relationships.

Staff were aware of how to protect people from avoidable harm and were aware of safeguarding procedures.

People had been asked for their consent to care and treatment and their wishes and decisions respected. The provider adhered to the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008. However the provider must ensure that the Care Quality Commission is notified of all successful applications for DoLS.

Medicines were safely stored and administered and people received their regular medicines as prescribed. However there was a lack of policy and procedures in place to ensure consistency in the administration variable dosage medicines.

People's needs were assessed and plans were in place to meet those needs. Risks to people's health and well-being were identified and plans were in place to manage those risks. Referrals were made to healthcare professionals but were not consistently followed up.

People's nutritional and dietary requirements had been assessed and monitored but meals were not always nutritionally balanced.

There were no robust systems in place to assess and monitor the quality of the service. There was also no formal system of gathering the views and opinions of people who used the service.

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 consistently safe

People received their prescribed medicines on time. However a lack of policies and procedures for the administration and ordering of medicines meant people may not receive their medicines in a consistent manner.

People had risk assessments but these were not always effective in maintaining people's safety.

People said their needs were safely managed. Staff knew how to protect people from abuse and avoidable harm. However there were no formal procedures in place for staff to follow in the event of an allegation being made.

The provider had a recruitment procedure, however not all checks had been completed.

Is the service effective?

Requires improvement

The provider sought appropriate support and guidance from healthcare professionals when required but referrals were not always followed up.

People said that the food choices were good and they had sufficient to eat and drink. However the menu offered was not always balanced.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) was being met but some issues were identified about consistency in adhering to the legislation. For example, the provider did not always notify us when an application for a DoLS had been agreed

Is the service caring?

Good

The service was caring.

Although staff were mostly kind when they spoke with people occasionally they could show their frustration.

People spoke positively about the approach of staff and described them as kind, caring and respectful.

People's privacy and dignity was respected and staff had a good understanding of people's needs.

People were involved as fully as possible in how they wished to be cared for.

Summary of findings

Is the service responsive?
The service was responsive.

People's care and support needs were assessed. Detailed information was provided for staff about how they were able to meet people's needs in a personalised way.

People did not know how to raise a formal complaint but were sure any concerns or complaints would be dealt with.

Good

Is the service well-led?
The service was not consistently well- led

There is currently no registered manager for this service.

Although staff felt supported by the manager, they did not feel that the provider or business manager supported them.

Quality audits were limited so the provider may not always be aware of what is happening in the service. There were no systems in place to ask and record people's views of the service.

Requires improvement

Chataway Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 25 August 2015 unannounced, we returned announced on 26 August 2015.

The inspection team consisted of two 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. Our expert-by-experience had expertise in understanding services for people with dementia.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We reviewed the previous inspection report, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service for their views.

On the day of the inspection we spoke with 11 people who used the service, three staff members and two visitors. We spoke with the provider and the manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at three people's care plans, three staff files and records associated with the management and running of the service. This included policies and procedures and records associated with quality assurance processes.

Requires improvement

Is the service safe?

Our findings

People told us that sometimes they felt there could be more staff as mornings could be very busy. One person said, "They do try their best, but you know, some people need two workers and therefore you are left with one (member of staff) or maybe none at times." Another person told us, "Morning-times can be a bit hectic and the girls seem to be chasing their tails. Everybody needs attention." A visitor said, "I think the older ones know how to keep my [person who used the service] safe but younger ones not so much." We were also told by a visitor, "They have done what they can to reduce the risk of falls, they have put a special mat on the floor."

Staff said they felt there were generally enough staff but that there were times when it was busier than others. One care staff told us, "Mornings are always the busiest, but we usually manage. We work well together and the residents understand we can't be everywhere."

During the two days we inspected the service we saw three staff on duty during the day. The manager told us that three staff are always available during the day and at night they have two care staff. Records confirmed staffing arrangments.

We were told that in the past there had been an unwillingness to cover shifts amongst staff and agency staff had been used. This had now improved and when people were unable to work they had staff who lived locally who were willing to come in at short notice.

All the people we spoke with told us they felt safe, A person said, "I've never had a fall yet, let's put it that way," another said, "The girls (care staff) always look out for you, seeing that you are steady on your feet as you go along."

We had been notified by the manager that a person had fallen and when we looked at the falls records we saw that this person had experienced several serious falls. We discussed this with the manager who told us the person wished to remain independent and so staff had to balance the person's safety with their wish to do things for themselves. We spoke with the person who told us they liked to walk and do things, "But sometimes I'm a bit wobbly on my legs".

The manager told us they were investigating different forms of equipment such as alarms to support people to remain independent but safe.

People told us that staff treated them well and they did not feel bullied or intimidated by staff. One person told us, "Bullied? I think the workers would rather cuddle me than bully me!" A visitor added, "There are very kind to me too."

Staff we spoke with had a good understanding of the different types of abuse and were aware of how to report any safeguarding concerns.

The manager told us that staff had completed on line training for safeguarding but had yet to complete a more detailed training course offered by the local authority. The service was undergoing changes following the new manager's recruitment. This meant that not all policies and procedures were in place this included safeguarding and whistle blowing procedures. The manager told us that these would be put in place as soon as possible.

Risks were assessed and management plans were put in place where risks were identified. We saw that risk plans had been completed for things such as falls, moving and handling and skin care. For example, risks around moving and handling were identified for one person. Actions that staff could take to support them safely were clearly detailed.

Risk assessments were reviewed on a regular basis to ensure that the information in them was up to date. Changes were identified as part of the review process and a record of changes were kept at the front of each person's file.

Staff maintained records of all accidents and incidents. We saw these were audited by the manager on a regular basis. We looked at records for January 2015 to June 2015. These showed that all incidents had been reviewed and action had been taken to reduce further risks. This showed the provider had reviewed and analysed accidents and incidents to see if any changes or action should be taken to prevent future occurrences.

Personal fire evacuation plans had been completed and were kept in people's rooms to advise staff of how to support them in the event of an emergency. Fire safety procedures and checks were also in place. This included safety checks on equipment and the premises. An external company had written a fire risk assessment to identify risks

Requires improvement

Is the service safe?

that were in place and control measures for these. There was information from the company who carried out testing on the alarms to say that work needed to done to make sure these were safe. A note had been made to say this had been done, but there was no paperwork from the company carrying out the work to confirm this. The provider told us they would ensure that the paperwork was obtained to show the work had been completed.

There was a record of maintenance work that needed to be carried out. Records were not well maintained and it was not always easy to identify what work had been completed. We brought this to the provider's attention who said they would make arrangements to improve the record keeping.

We looked at staff recruitment procedures. The manager told us that no one worked at the service without the required background checks being carried out to ensure they were safe to work with the people who used the service. We looked at the recruitment records of three people who worked at the service. References and health checks were completed before the person started work at the service. A Disclosure and Barring Certificate (DBS) had been requested. Records indicated that the DBS certificate had not been seen for one person. There was a checklist in place for all pre-employment checks but this had not been fully completed. We brought this to the manager's attention who told us they would follow this up and ensure they made the appropriate record of the checks.

The manager told us that they looked at the skill mix of staff when creating rotas as well as ensuring that the two male carers, who were employed, did not work on the same shift. This meant that people were cared for by staff with the skills and abilities to meet their identified needs, as well as the gender they preferred.

People told us they received their medicines safely. We looked at the management of medicines including the medicine administration records for everyone who used the service. There was a policy in place to support the safe management of medicines. Arrangements were in place to obtain, administer and record people's medicines. The manager could explain these procedures but they were not written down so if the manager was not available, other staff may not be able to complete the task. The manager agreed that they would make a record of the procedure.

All medicines were stored securely. The temperature of the cupboards was checked regularly throughout the day and was within the required limits for safe storage of medication.

We saw that medicines were supplied from the pharmacy in a system that reduces the risks associated with the administration of medicines. Where medicines were not supplied in this way we saw staff administering them without touching the medicines. This ensured that people received their medicines safely and free from possible cross infection.

There was a procedure for returning medication which staff were aware of and followed. Medicines were stored safely but there was a risk that the system was not robust enough. The manager is going to speak to the pharmacy to see what the most appropriate system is.

Where medicines were prescribed as required and labelled as such, there were some protocols in place to advice staff when to administer them. However they were not in place for all medicines, and had not been reviewed. The manager said she would develop these for each person and each as required medicine.

Where medicines were prescribed in variable doses, for example 'take one or two tablets', variable dose protocols were not in place. There was a potential risk that people may not receive these medicines when they needed them as there were no clear guidelines in place for staff to follow. We brought this to the manager's attention and they said they would develop appropriate guidance for staff to support them.

Requires improvement

Is the service effective?

Our findings

We had received information of concern telling us that the provider had falsified training records. We discussed this with the new manager who told us that they were unaware of such a practice. We looked at training records and we could find no evidence that this practice had taken place.

People we spoke with told us that they thought staff had the skills and abilities to meet their needs. One person told us, "Oh, yes, they are just great and seem to know what they are doing." Another person who had complex needs said, "They are trained enough about the basic requirements I would say. They are very confident and understand my needs I think." A visitor told us, "Yes, they are trained as care workers but they don't have the skills of nurses." Another visitor said. "This is a very comfortable little home. I think the staff have the knowledge to care for my [person who used the service]".

A member of staff told us, that they felt their training had been limited since being employed in service. Whilst they received the necessary basic training they felt the management had not been as supportive with the development of their National Vocational Qualification (NVQ). They told us that it was only recently that the new manager had made arrangements for them to start their NVQ course and they had worked at the service for more than a year.

All training is provided by an external training company and was mostly distance learning or on line courses. Records indicated that staff had completed basic training to support them in their day to day role. The manager was also going through all the training courses to ensure they were fit for purpose as well carrying out competency checks on staff following their training. This was to ensure they knew what they were doing and were putting their training into practice. The manager explained they were in the process of enrolling all staff on their NVQ two or three. We saw records that confirmed this.

Staff told us they received both formal and informal support from the manager. We saw records that confirmed what we were told. This demonstrated staff were supported and received opportunities to review and develop their practice.

One staff member told us they received an induction before they were allowed to work on their own. This included training and shadowing of more experienced staff. We saw an example of completed induction plans that confirmed what we were told.

A staff member who administered medicines described their training as completing a distance learning booklet, then shadowing a more experienced member of staff. They were then observed by the manager to ensure they were competent.

We saw that staff asked people for their views before they provided any type of care intervention. People's plans of care instructed staff to always ask for the person's consent every time they were supporting with personal care.

We saw DNACPR (Do not actively resuscitate) orders in place for two people. These had been completed by medical professionals. In one case the person had been consulted. The manager told us that these were only in place for people, who following discussion with the person, the doctor and the family, it was felt necessary.

We found that care records made reference to people's capacity and how to involve them in making decisions, however, decision specific mental capacity assessments had not been carried out.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), is legislation that protects people who are not able to consent to care and support. It ensures people are not unlawfully restricted of their freedom or liberty. We saw that where people were being deprived of their liberty it was done in their best interests in accordance with the law. The manager had applied for a DoLS for one person but had failed to notify us. They made arrangements during the day to send us the correct notification.

People were offered PRN (as required) medicine and we saw this refused by four people. Information in people's care plan or medicine records was not clear to show that the person knew what the medicine was for and that they knew what they were refusing. The manager said they would record how it was known that people were making an informed choice.

Two people told us they were involved in their care planning process and others said their family members had

Requires improvement

Is the service effective?

been involved in this process. A visitor confirmed that they felt very involved in the initial care planning for their relative and said they were consulted with regard to any change and updates.

The food was generally highly praised. A person told us, "The food is fabulous!" The cook asked each person what they wanted for their main meal during the morning. A person told us, "Oh yes, he came around but I cannot remember what I ordered!"

We looked at four people's care plans and found that they contained detailed information about their dietary needs, any equipment needed and their preferences. Information was recorded at each meal about what people had eaten and drank.

Each person had water available at all times, drinks were offered throughout the day and each person was given a choice. There was bowl of fruit and a bowl of sweets available for people to eat when they wanted. We saw that this was replenished each day.

A menu with choice of main meal and tea was displayed and this was updated each day. The tea-time menu was not nutritionally balanced (choice between two pizzas, chips, bread and butter and cake). We discussed this with the manager and provider who said they would discuss this with the cook and look at introducing meals that were balanced and included more fresh ingredients.

One person had a reduced appetite and the staff encouraged them to eat by providing them with smaller, attractively laid out meals. Where necessary people were provided with equipment such as plate guards and adapted cutlery to help them eat independently.

Some people chose not to eat in the dining room and staff supported this. We saw two people having their meals in bed whilst others ate in the lounge. We did note there was a period when the three staff were standing in a row observing people eat and not interacting. One member of staff had a clip-board, making notes about what each person had eaten. We discussed this practice with the manager as it felt institutionalised. The manager said they would speak with the staff.

People told us they were able to see a doctor when they needed to. One person said, "I just have to say I don't feel well and they ask me if I need to see a doctor. They are very good like that." A visitor told us, "If anything is wrong with my relative they phone me straight away and get a doctor."

We saw evidence of health professional's involvement in people's care plans. Appropriate referrals had been made and the advice from health professionals was recorded in the care plan and if necessary in the medicines file. For example, we saw that one person had a pressure sore on admission to the home. This was referred to the district nurses and a timeline of all visits from the district nurses, and actions taken was recorded. The information was detailed in the care plan along with the advice from the nurses and body maps were in place to document pressure areas.

We also saw that another person had lost weight and staff had brought this to the manager's attention. A referral was made to the dietitian, who had contacted the manager to arrange to visit. The person was in hospital and it was agreed to follow this up when they returned to the home. This had not yet been followed up. We brought this to the manager's attention who agreed that they would do this.

When speaking with a member of staff, they said that the thing they liked most about working in a care home was the care-work, interaction, rapport and trust they built up with people who used the service. However on the downside of working in this particular service was the requirement to do cleaning and laundry tasks, taking them away from the actual care-giving. We discussed this with the manager who told us would look at how this could be improved.

The service had two shared bedrooms. Both had single sex occupancy and the manager told us they were looking at how to improve the privacy for people who shared. We raised concerns with the manager that due to the way the bedrooms had been split by a partition wall it meant that one person had no natural light and needed to use an artificial light at all times. Plus there was no means to ventilate the partitioned side as a result the room was stuffy. The manager said they would investigate ways of improving both these issues.

Good

Is the service caring?

Our findings

We heard staff sometimes talk to people with frustration. We heard on staff member say, “Can you not wait until you’re finished your dinner, for goodness sake?” The person did not appear to be effected by this response.

At other times staff spoke to people in a caring manner and treated them with kindness. Staff approached people with a calm, steady manner. For example, we saw staff listen and respond positively with a person. Staff asked permission of person before undertaking a task. For example, we heard, “Can you lean forward just a little bit more, [person who used service]? Is that better for you? Just let me put a pillow at your back so you’ll be a bit more comfortable. How’s that?” Another member of staff was seen to gently encourage a person with a limited appetite to eat.

Throughout our inspection staff were kind but they were focussed on getting the task done. There were pleasant interactions; however staff did not always appear to promote people’s emotional, mental or social health by talking to people in a meaningful way. We discussed this with the manager, we were told that they were aware that staff needed more time to positively interact with people and develop relationships.

People we spoke with were positive about the approach of staff and described them as caring, kind and respectful. Comments included, “I think all the staff of lovely here, kind and caring.” “The girls are all wonderful. You can’t fault them.” “There are a couple of special ones but there are none that are bad.” “I’d give (named care worker) a gold star!” and “Absolutely lovely staff”

We saw staff knock on people’s bedroom door and ask permission to enter, showing respect for people’s dignity. The manager had also arranged for ‘Do not enter care in progress’ signs to be used to ensure staff were aware that personal care was taking place.

The service had two shared bedrooms; each person who used a shared room had a risk assessment in place to show how their privacy and dignity would be maintained.

People said that the home had provided a birthday cake on their birthday. This was confirmed by staff. We were told that the service makes an effort on people’s special days. A staff member was aware that it was one person’s birthday the next day and we heard them reminding the person of this as they couldn’t remember.

Staff were able to tell us about people’s likes, dislikes and preferences. We saw that important family members and important dates were recorded in people’s files. This showed that staff read and understood individual care plans.

The manager told us they were organising events to try to raise money so they could take people out to different activities. Staff were willing to come in on their days off to take people out for organised activities. We saw that a trip to a local attraction had been arranged. Those people who were going told us they were looking forward to it.

Staff had a good understanding of how they were able to promote people’s independence while supporting them with their needs. For example by getting people to do as much as possible for themselves whilst supporting them to carry out their personal care. We saw information in the care plan about what type of assistance each person required, the level of assistance required, how they like things to be done and what they could do for themselves. This meant that staff could focus on what the person could do for themselves and support their independence.

We saw that staff assisted people at lunchtime and respected their dignity by discreetly offering help. For example, a person spilt some food; staff cleaned this up quickly and without comment so as to not to draw attention to it.

A visitors told us they were always made welcome when visiting the home. One visitor said that staff even knew how they liked their tea.

Good

Is the service responsive?

Our findings

Before people moved to the service their needs were assessed to ensure the service could support people appropriately. Not all people we spoke with could recall their involvement in the development of their care plan.

People told us, "They seem to know my little ways, how they know, I don't know." Another person said, "Yes, I feel they are always asking me if this is alright or that is alright. It is nice to be asked. You feel a part of it somehow." We were also told by a person, "I am not a number! I honestly feel they have your best interest at heart."

Care plans were developed detailing people's care, treatment and support needed to ensure personalised care was provided to each person. Additionally, people's preference to male or female staff for personal care was recorded. Care plans were centred on the person and their views and preferences. For example, we saw that one person liked a particular brand of hairspray and another stated 'prefers spray deodorant to roll on'. This information provided staff with the required knowledge to provide care and treatment that was personalised to meet people's individual needs.

Where people had specific health care needs such as diabetes there was information for staff on how to recognise the different aspects of the illness. For example, there was information on the difference between hyperglycaemia (high blood sugar) and hypoglycaemia(low blood sugar). This meant staff knew how to respond to people's needs in a personalised way.

People's personal emergency evacuation plans were personalised, providing staff with details such as how the person walked and what equipment they would need to leave the building or what support was to be provided if they were unable to leave.

Review sheets at the front of people's care plans showed that the care and support was being updated on a regular basis. Visitors we spoke with confirmed they were kept up to date with changes in their relatives care plans and their changing needs. One visitor said, "I am kept up to date, I have no concerns about the care my [person who used the service] receives. I would recommend this home."

The manager told us that they try to involve people where possible in contributing to their care plan as well as reviews. The manager also said that they offered to show people their plans. People we asked could not recall seeing their plans. One person said, "They may have shown it to me but I can't remember."

Whilst people's interests and hobbies had been identified and recorded we did not see during our inspection that activities for people to participate in were offered. People were seen to watch television in the communal lounge or they remained in their room.

Due to the design and layout of the lounge there were three televisions all quite close to each other all showing different channels. People we spoke with did not consider this to be a problem.

The manager told us that earlier in the year some of the people who used the service had planted herbs and the cook had used them when preparing the midday meal. They had been very pleased to be eating something they had grown.

People who used the service told us they appreciated their nails being filed and polished, this was carried out by care staff as an individual activity. There was no visiting hairdresser but the manager said they were in the process of acquiring the services of one.

The manager was the owner of a PAT (Pets as Therapy) dog, they brought it in on a regular basis. We also saw people who used the service were expecting a visit by an organisation that brings in different animals into services. This could include snakes and lizards for people to hold and experience what they felt like. We saw photographs from a previous visit. The manager was also going to contact Age UK for further advice on positive activities for people living in a care home.

We saw that staff communicated with people in their preferred way and allowed them time to understand what was being said.

We saw a handover between staff. All staff who were on shift were present but still available if someone needed assistance. When someone requested help during the handover one staff member went straight away to support the person. Key information about each person and what they had done that morning was passed over to the staff that were coming on duty so they knew the needs of people they would be supporting.

Good

Is the service responsive?

People told us they had no complaints about the place but they were unsure how to make a formal complaint if they needed to. The visitors both said that if they needed to complain they would approach the care worker in the first instance, then the manager. One visitor said, “If I was at all concerned I would phone social services or you.”

People who used the service maintained their links with families and friends as they were welcome in the home at all times. One person said they felt included in the “outside world”. Care plans identified where families or friends took people out to visit the local pub or community activities.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager for this service. The provider told us they would ensure that the manager applied for registration as soon as possible. We spoke with the business manager after the inspection to confirm that the process had started.

People we spoke with said that the manager was approachable and they could talk to them about anything. People who used the service knew who the manager was as did the two visitors we spoke with. One visitor said, "I am able to talk to [name of manager] if I wanted to."

The manager said that they do not hold formal meetings with people who used the service rather they would prefer to talk to each person individually to find out any concerns or suggestions. The manager did not record these conversations so we were unable to see what action, if any, had been taken as a result of what they had discussed.

One member of staff we spoke with said they felt supported by their colleagues and their manager however felt significant lack of support from the business manager and the provider. They did not feel valued.

The manager told us they were developing strategies to encourage and improve staff morale. As part of this strategy they had introduced a 'staff of the week' initiative. The manager asked people who used the service their views of the staff to help decide who would be chosen that week. We saw a poster confirming that this initiative had started.

Staff meetings were held regularly and the manager told us that they outlined their expectations about standards of care during these meetings. Staff confirmed that team meetings were held every six weeks and the manager discussed standards during these meetings.

The manager was spending part of their working week as a carer and the rest as the manager. We discussed this with the provider and raised our concern that the manager was unable to carry out all of their managerial duties if they were not given adequate time. The provider assured us that they intended the manager to be full time once their probation period was over. This was due to finish in September 2015.

The manager carried out a weekly audit of medicines. This was a quality audit to make sure that medication was in stock, had been administered, and all paperwork had been completed. On one occasion the audit stated that there was sufficient medicines in stock but shortly afterwards they ran out and staff had to make alternative arrangements. This meant that the audit was not robust.

The provider told us that currently the business manager carried out other aspects of quality assurance of the service. This included ensuring the policies and procedures were in place and up to date. We found that a number of these procedures were not in place. This meant staff may not know what to do if an incident happens.

People told us they had not been formally asked their opinion of the service through surveys but they were able to talk to the manager. The manager told us that they had not carried out any quality assurance surveys of people who used the service. However as they currently worked part of their working week as a carer they routinely asked people what they thought of the service and if they had suggestions for improvements. The manager had not recorded these conversations so we were unable to see what action they had taken as a result of people's comments. They did tell us that they had arranged a trip to a local attraction following one discussion. We saw information about this trip.

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.

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.