Eleanor Palmer Trust

Eleanor Palmer Trust Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 February 2016 and was unannounced. Eleanor Palmer Trust Home is a care home that is registered to provide accommodation and personal care for up to 32 people. The home is run by The Eleanor Palmer Trust, a voluntary organisation. There were 30 people living in the home at the time of this inspection.

The home did not have a registered manager as the previous registered manager was no longer working at the home. 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 an acting manager in place who advised that recruitment was being undertaken to appoint a new manager to register with the Commission.

At the previous inspection in July 2014, the home was not found to be sufficiently clean. We found that the home was clean and there was a deep cleaning programme in place during the current visit. The home was also in a good state of repair, and equipment was maintained appropriately.

There had been an increase in staffing numbers since the previous inspection. Safe systems were in place for recruiting staff. However staff had not receive sufficiently regular supervision meetings and training was not always provided in a format that they found useful, within the last year. A variety of activities were available to people, however no activities were available to people in the afternoons.

People told us that their care needs were met, and their views were taken into account. They were provided with their medicines safely. People who were unable to consent to care had best interest decisions recorded for them, and deprivation of liberty safeguards were in place for people who required this.

Detailed care records were in place regarding people's care however this was not always easy to access due to the formats for recording. Accident and incident records did not include a section for learning from what had happened, and improvements were needed in the recording of bruising and skin marks for people living at the home.

Staff showed a good knowledge of people's life histories and preferences regarding their care and support needs. They were clear about the procedures for reporting abuse and felt that management listened to their views.

People were provided with a choice of food at meal times, and were supported to eat when this was needed. They spoke positively about the food provision in the home. People's health needs were met, and they were supported to consult with health and social care professionals as needed without delay. They had the opportunity to be involved in decisions about their care and how they spent their time at the home. They and their relatives attended meetings or spoke directly to a manager to raise any issues of concern.

The provider had systems for monitoring the quality of the service and engaged with people and their relatives to address any concerns. When people made complaints they were addressed appropriately.

At this inspection there was one breach of regulations, in relation to staff supervision and training. 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?

Good

The service was safe. Staff knew the correct procedures to follow if they suspected that abuse had occurred. There were assessments in place to minimise identified risks to people.

Safe recruitment procedures were in place, and the home had increased the staffing provided since the previous inspection.

People received their medicines safely. The home was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective. A training programme was in place, but staff had not been receiving regular supervision sessions in recent months, and some staff did not find training methods effective, for example the lack of face to face moving and handling training.

Staff understood people's right to make choices about their care, and the requirements of the Mental Capacity Act 2005, and records reflected best interest decisions made for people unable to consent, and Deprivation of Liberty Safeguards.

People received a varied choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to health care professionals as required.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported, and understood their preferences and life histories.

There were opportunities for consultation with people and their representatives about their care and support. People's religious and spiritual needs were met and festivals for different cultures were celebrated within the home.

Is the service responsive?

Requires Improvement

The service was not always responsive. A range of activities were available for people, however there were no activities available in the afternoons.

Care and monitoring records were detailed but sometimes lacked important information, to ensure that people's needs were met fully and responsively.

People using the service and their relatives were encouraged to give feedback on the service and use the complaints system.

Is the service well-led?

Good

The service was well-led. The provider had systems for assessing and monitoring the quality of the service. A new registered manager was being recruited for the home. People found the management team to be approachable and supportive.

Eleanor Palmer Trust 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.

At the previous inspection of the service in July 2014 we found that the provider was not meeting one of the regulations inspected relating to the cleanliness of the home.

Prior to the current inspection we reviewed the information we had about the service. This included an action plan sent to us by the provider to address the above breach and any notifications of significant incidents affecting people living at the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 23 February 2016 and was unannounced. The inspection was carried out by two inspectors, and a specialist advisor who was a social worker with professional experience of working with older people.

At the time of the inspection there were 30 people living at Eleanor Palmer Trust Home. We spoke with 13 people living at the home, and seven relatives or friends who were visiting people there. We looked at the care plans, risk assessments, and daily records relating to eight people, finance records for three people, and medication administration records for seven people.

We observed care in communal areas across the home, including medicines administration, mealtimes, and activities. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We spoke with three senior care staff and four care assistants, an activities coordinator, the chef, the acting manager, deputy manager and service manager. We also spoke with a health and social care professional providing support to people at the home.

We looked at seven staff files (including three new staff) for recruitment, training and supervision records, the last month of staff duty rotas, accident and incident records, selected policies and procedures, and records relating to the management of the service.

Good

Is the service safe?

Our findings

At the previous inspection in July 2014, we found insufficient standards of cleanliness within the home. The provider sent us an action plan detailing actions taken after the inspection including recruitment of further domestic staff to work at the home and implementing cleaning checklists in each person's bedroom and daily senior staff checks.

During the current inspection people and their relatives told us that they were satisfied that the home was kept clean. One relative told us, "The room is always clean," and another noted, "I could not fault the cleanliness in the home." During our visit the home was found to be clean and bright in all areas inspected. The acting manager and staff told us that they had recently noted a drop in standards which had been addressed in recent weeks. The acting manager had arranged supervision with domestic staff, and put in place a new cleaning schedule, to provide a deep clean of the home. She advised that she had received support from the provider's trustees to book a contractor for two days to deep clean the home's lounge and dining areas. Use of the adjoining sheltered accommodation lounge was arranged for these days to avoid disruption to people living at the home.

Five domestic staff were employed at the home, and there was a vacancy for a weekend cleaner at the home, which the acting manager was recruiting to fill. Cleaning materials were kept locked and secured, and we observed personal protective equipment in place such as gloves and aprons to support infection control within the home. Individual slings for the use of each person requiring support with a hoist had recently been provided to reduce the risk of cross infection within the home. The home was awarded five stars (the maximum) at the most recent environmental health inspection of the kitchen in November 2014.

People said that they felt safe at the care home. Staff we spoke with were clear about how they should respond to safeguarding concerns. They could describe the different types of abuse people might experience, and knew who they should report to if they had concerns that somebody was being abused. Staff were aware of signs to look out for indicating safeguarding concerns for people living in the home. They had received training in safeguarding adults and we saw evidence that incidents had been reported appropriately. They were also aware of the provider's whistle blowing policy and indicated that they would use it if required.

Assessments were in place to ensure that risks to people were identified and addressed, and staff signed to confirm that they had read them. Risks recorded included weight loss, falls, developing pressure ulcers, the home environment, and behaviour that challenged the home. They were reviewed on a monthly basis or more often if required, with relevant monitoring recorded for example regular weight checks. People also had a record of their personal property, and appropriate records of money kept for safeguarding on their behalf, and any financial transactions undertaken.

The acting manager told us that new pull cords (to summon assistance) had been installed in all the bathrooms. She also advised that the home had been measured for radiator covers, and quotes were being obtained to install these without delay. Security within the home had improved since the previous

inspection, with finger print sensors in place for opening the front doors. However we were concerned to find that doors connecting to the stairways on all floors, were not protected by any measures, to prevent a people who could not safely use the stairs from accessing them. Staff did not feel that this was a problem in view of the needs of the current people living at the home. However the acting manager acknowledged that this might become a problem for some people who had dementia. Following the inspection she arranged for quotes to be obtained to fit numerical door pads on doors leading to the stairways, and advised that these would be installed without delay.

During the morning there were six care staff on duty, with a senior staff member, and in the afternoons there were three care staff with a senior staff member. At night there were three care staff with a senior staff member sleeping in (who could be contacted in an emergency). Senior staff were responsible for medicines administration and also assisted with personal care. Since the previous inspection staffing in the home had been increased by one care staff in the mornings and at night. However we noted that having only four staff members on duty in the afternoons/evenings had an impact on activities/stimulation provided for people, and was also a particular challenge in the event of an accident. On the day of the inspection we observed one person having a fall, which required medical assistance, and required significant time from two staff members. This left only two other staff to support the remainder of people at the home. We brought this to the attention of the acting manager who undertook to review staffing numbers during this time period.

Safe recruitment procedures were in place to ensure staff were suitable to work with people in the home. Staff confirmed that they had undergone the required checks before starting to work at the service. We saw evidence of application forms, interview records, disclosure and barring checks, written references and confirmation of each staff member's identity to ensure their suitability. Training certificates showed that staff had received training in relevant health and safety topics including moving and handling, food hygiene, and fire awareness.

People told us that their medicines were given on time. We observed staff administering medicines appropriately. Appropriate storage arrangements were in place including for controlled drugs, with temperatures monitored for refrigerated and room temperature storage. In the past two weeks the service had changed pharmacy provider, so that they were now receiving most medicines in monitored dosage blister packs. The staff team were due to receive training from the new pharmacy two weeks after the inspection. Only one person was able to take responsibility for their own medicines and was supported to do so.

Senior staff showed awareness of the timing for each person's medicines including whether medicines should be taken before or after meals. The medicines records had been completed accurately, including records of medicines prescribed on an occasional basis (PRN). We observed that staff were careful to monitor people's needs in order to determine when to administer PRN medicines. Controlled drugs were stored and administered appropriately, with double signatures for each administration. Audits of controlled drugs were undertaken in July, September, and November 2015 and found to be fully compliant.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the staff support at the home. Staff told us that they felt well supported by the home's management and senior staff, and we noted that there had been little turnover of staff in the last year. However we found that there had been little staff supervision or appraisal sessions for care staff and other staff members in the last year.

Staff and the acting manager confirmed that supervision was behind. We observed that there had been no recent supervision for senior staff or care staff (with two exceptions) for over a year. The provider's own policy on supervision indicated that individual sessions should be provided on a two-monthly basis.

There were records of staff receiving induction training on starting work at the home. Staff team training records were not up to date, so it was not easy to monitor which staff members were due for new or refresher training. However staff appeared to have undertaken mandatory training. Online training was being provided in all courses other than safeguarding adults. Staff told us that they did not always find this way of learning effective. We were particularly concerned to find that moving and handling training was being provided in this way. One staff member said that they wanted more training on managing challenging behaviour.

The evidence in the paragraphs above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People said they were able to make choices about their care. All people who were able to do so had keys to their bedrooms. They told us that they locked their rooms when going out for activities, meals and walks. We observed that people were able to move around the home without restriction. There were assessments available regarding their capacity to make decisions and consent to their care. Staff had received training on the MCA and could explain the process to be followed if they believed that people were not able to consent and make decisions about their care. One staff member specifically mentioned the priority of preserving dignity for people who did not have capacity to make their own decisions. Staff demonstrated a good understanding of how to seek people's consent. They ensured that people with capacity to do so were

supported to make their own decisions and choices, asking their permission to carry out each task. There was clear documentation in place to record decisions about whether resuscitation should be attempted.

DoLS applications had been made for people where required, and the relevant documentation was easy to find in the care files alongside conditions relating to the safeguards. The acting manager provided evidence that a condition was being met in one case, however we noted that this evidence should be recorded in the care file also. She undertook to ensure that this was clearly recorded.

People were positive about the quality and choice of food served in the home. Comments included, "The food is good," "Lunch was lovely, beautiful," "The food is to my liking," "The food is excellent," and "The food is okay." One person said that if they wanted something special the chef would buy it for them. One person said that they preferred traditional English food and that when the chef prepared food from other countries, they were always offered a replacement. A relative commented that there were always drinks offered to people when they were in the lounge.

People were offered choices of food and drinks, and were complimentary about the food served to them. A varied and nutritious menu was provided, with a six week cycle repeating in the winter, and a four week repeating menu in the summer. However although there was an alternatives menu provided, we were concerned to note that only one option was recorded for each meal on the main menu. Meal choices were written on two blackboards in the dining area, one for the main meal and one for alternative choices. However these blackboards were not easy to see without standing right in front, and would have been difficult for many people to see or comprehend. We discussed these issues with the chef and acting manager who undertook to review the way options were displayed. We were told that following the inspection, the chef had ordered a combination notice board and white board for use in the dining room to display menus more clearly.

The atmosphere during lunch was calm, happy and relaxed. People were offered food and drinks gently and served carefully, cutting up food for those who needed it and supporting others with eating as required. Staff on duty ate at the tables together with people living at the home. Staff told us that they liked this policy and thought this was good practice. We observed friendly inclusive conversations and a relaxed atmosphere in the dining area during the meal time. We observed a staff member carefully supporting one person who was sleepy at lunchtime. This was done by prompting them playfully each time they were ready for another mouthful.

People's nutritional needs were assessed and recorded in their care plan. Staff were aware of the dietary needs of people who had diabetes or who were on particular diets such as soft food or enriched food. Food and fluid charts were in place for one person, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietitian or speech and language therapist if they were having difficulties swallowing. Nutrition was monitored by monthly weight records. One person had been referred to the dietitian following weight loss and their care plan had clear documentation of all the recommendations for supplementing their meals. The chef was aware of their dietary needs and staff were observed to be following the recommendations and giving discreet monitoring and encouragement to the person at lunchtime.

People had access to health and social care professionals. They were registered with local GPs of their choice, who visited the service when required. People had annual health checks with their GP and could see other health care professionals such as a dentist, speech and language therapist, optician or chiropodist when needed. Care plans reviewed showed evidence of good links with a local memory service and

psychiatric services when needed. Clear records were maintained of the outcome of health care professional visits.

Good

Is the service caring?

Our findings

People felt well cared for, and that they were treated with dignity and respect. Comments included, "It's lovely here," "Staff are friendly," and "Staff are kind and caring." The home had two resident cats, which gave pleasure to a number of people living there. One person mentioned that staff did not always have time to chat with them, as they were always very busy.

We observed staff across the home to be kind, attentive and friendly when talking with people living at the home. Care staff showed patience and skill at supporting people if they became anxious, and appeared to know people's preferences well, speaking with them as individuals. We observed staff respecting people's need for privacy and dignity, knocking and waiting for a response before entering anyone's room. Staff told us that they always ensured people's privacy and dignity was protected and respected especially when providing personal care.

Staff were generally gentle, respectful and cheerful. People seemed to feel relaxed with staff and there was some friendly banter between staff and people living at the home. We observed good interactions between staff and people they were assisting with meals, and staff sitting with people to ensure that they had eaten enough. We also observed kindness, good tone of voice and gentle manner when staff supported people to move around the home, to access the toilets, and to find a seat for mealtimes. Many of the staff had worked in the home for a number of years and demonstrated clear understanding of how to assist each person as an individual.

We observed respectful compassionate co-operative behaviour amongst the staff team in their dealing with people. All staff had dementia awareness training including a test, and they practiced good support of people with dementia, including allowing them freedom to walk around the home without restriction. One person (who had advanced dementia and enjoyed walking) was supported by a member of staff to continue walking but was also encouraged to take breaks, sit down and enjoy chats with other people.

Some people were able to be involved in making decisions about their care. Care records included a place for people or their representatives to sign to evidence consultation, and record their opinion, and some of these had been completed. Records were centred on the individual person including their preferences, and some included the person's views or those of their relatives. They included a life history with a clear indication that relatives had been involved when appropriate. One person who told us that they were sometimes lonely, had a befriender who visited them regularly.

The service provided support for people to practice their religion, including a monthly church service held at the home and weekly holy communion services. One person living at the home had set up a bible reading group. Chinese new year had been celebrated at the home, and plans were in place to celebrate St Patrick's day also. We observed an art installation created by people at the home to celebrate the recent Chinese new year. All of the people we spoke with liked their rooms, and the rooms we observed that personal possessions and individual character.

Requires Improvement

Is the service responsive?

Our findings

People were largely satisfied with the care provided to them and responsiveness of staff. A relative told us, "I have no complaints, it is a good place," and another relative praised staff support for encouraging people to get up out of bed and make use of the communal areas. One relative felt that staff could interact more with people for example when sitting in the lounge in the afternoons. One person said that they thought staff could support them more to maintain their own independence, for example making their own bed.

Care plans held clear records of each person's needs and risks, and how they should be supported. They were generally updated every month, however many had not had a review in February as yet although due at the start of the month. The acting manager advised that they tried to update one person's care plan each day but this was something that had not happened since the departure of the former registered manager on 1 February 2016.

A wide range of areas were covered in care plans including a pre-admission assessment, and assessments covering falls, pressure ulcers, nutritional risk, communication, safety in the environment, mobility, moving and handling, and social and spiritual needs. There was evidence that families had been involved in the care plan by providing some background history and details of some preferences for their relative.

Although detailed, care plans did not always provide a clear and accessible holistic picture of each person, partly due to the layout, which did not include a short summary of important information about each person, without reading through the full folder. There were personalised elements in some files, for example providing one person with a hot water flask so that they could make their own hot drinks. However, records did not routinely include a section on people's likes and dislikes for example regarding food, or support to be provided for people with sensory impairments such as hearing and sight loss. Detailed daily records were kept, however these did not always confirm that support detailed in people's care plans was provided. For example one person's care plan indicated that staff should spend time in one to one conversations with them regularly to avoid them feeling lonely, but these were not recorded.

A senior staff member told us that they were looking forward to attending training on person centred care planning to be held later that week, and the acting manager confirmed that this had been undertaken for the staff team a week later.

Monitoring records were in place for people as needed, including detailed records for one person who required regular repositioning to prevent developing pressure ulcers, and food and fluid charts to ensure they remained hydrated and nourished. Accident and incident records were maintained as appropriate, however they did not include a section to record actions to be taken to prevent a reoccurrence. We were concerned to find that one person who had significant bruising visible on their legs, did not have any record of these bruises on the body charts and skin marks assessments in their file. We reported this to the acting manager, who advised that this issue had been addressed with staff shortly after the inspection. No behavioural charts were in use regarding people who had behaviour that challenged the service. Records were made in people's daily notes instead, but this made it more difficult to monitor changes in their mental

health.

People were given a choices about how they spent their time. They told us, "I've been painting today," and "I don't have time to get bored because I'm always doing different things." During our visit we observed an art group in the morning, and a bingo session in the evening for people wishing to participate. One person mentioned that they had enjoyed watching a film on birds, the previous week. However four people told us that they would like more activities in the afternoons. They told us, "It would be nice to do something in the afternoons other than sit in a chair," "Afternoons are long and boring," and "There's not enough to do." One person said they would like to go out more frequently, and another advised that they would like to make more use of the home's gardens over the summer.

There were no planned afternoon activities. We observed that in the afternoon of our visit, people were not engaging in any group or individual activities. We spoke with the activities coordinator who worked in the mornings, and one evening a week (for a bingo session which was very popular with people living at the home). It was noted that when the activities coordinator was not on duty, or taking leave, there were no activities conducted.

Art sessions were conducted every week with approximately ten people joining in. We observed this session and noted people were colouring printed images water colours, pencils or crayons. Another person enjoyed a jigsaw puzzle. The activities coordinator was also playing music in the background; people seemed to be enjoying the music and were singing along with it. The activities coordinator said that she was able to see people's confidence develop with each art session, and that she was also planning to start a knitting group. She said that some people liked playing games such as cards and dominos, but we did not see this recorded in daily records.

Other activities recorded for people included sing alongs, board games, 'question ball', quizzes, fellowship group meetings, manicures and pedicures, and entertainers booked on a quarterly basis including a recent theatre show. There had also been a recent 'Wild Science' visit in which people living at the home were introduced to and able to handle a number of animals including a snake, rabbit, millipede, and scorpion. One person said that they went out to a club twice a week and to the local church once a week with the help of transport arranged by the staff. Occasional trips out of the home were arranged. We observed photographs of people enjoying birthday celebrations and summer parties.

People were aware of the home's complaints procedure and told us that they felt able to complain if they were unhappy about anything. Records showed that complaints were taken seriously, with one care assistant dismissed for poor conduct as a result of complaints. Informal concerns raised with management were not recorded, to demonstrate the service's responsiveness. A relative told us that at first they had not felt listened to regarding concerns about their family member's physical health, but that they found that their concerns were however acted upon.

Good

Is the service well-led?

Our findings

People and their relatives were positive about the home's management. Relatives told us "Everything is alright," and "It's like a luxury hotel." There were photographs of the staff team and people living at the home in the home's reception, and the home was decorated with art work undertaken by people living at the home making it appear warm and homely.

The registered manager had left employment at the home on 1 February 2016, and a senior staff member was acting manager in the interim period. She told us that active recruitment was taking place for a new registered manager but a successful candidate had not yet been found. On the day of the inspection, three trustees conducted an interview for the position.

Staff felt comfortable in raising their concerns with the acting manager and knew she had an open door policy. They said that their concerns would be heard and acted upon. One senior staff member said that they had felt very well supported to take on more responsibility and had been promoted. Staff felt that a recent increase in staffing levels was evidence of good leadership within the home responding to staff concerns. One staff member mentioned the generosity of the trustees in supplying funds for gifts and parties for people living at the home at Christmas and birthdays.

Staff said they found the acting manager and senior staff to be supportive and visible around the home. Quarterly staff meetings and daily handover meetings were in place, at which staff could discuss any issues, and receive feedback from management. At the most recent staff meeting in December 2015 topics discussed included dementia training, mental capacity assessments, deprivation of liberty safeguards, care records, safeguarding, staffing, and Christmas preparations. A care staff meeting was already scheduled for the day after the inspection, and the acting manager provided us with minutes of the topics covered which included issues which were raised during our inspection. Topics covered included review of care plans, staff team work, infection control, accident reports, supervision sessions, and forthcoming medicines training.

The most recent residents meetings was held a week before the inspection, with information provided about the change of management, key working staff introducing themselves, activities, and food provision. These meetings were usually held approximately quarterly covering a range of topics relevant to the home.

Feedback surveys had been undertaken of people using the service and their advocates. In January to Feburary 2015 this covered the domain of 'safe' with 21 of 32 surveys returned and an overall score of 80 percent. Two people raised issues regarding insufficient staff to provide nail care, and people being left with food over their clothes after meals. In April to May 2015 surveys covered the domain of 'effective' with 17 of 32 surveys returned and an overall score of 96 percent. In June 2015 surveys covered the domain of 'caring' with 18 of 32 surveys returned and an overall score of 84 percent. In September to October 2015 10 surveys were returned, returned but no analysis was undertaken of the results. No other stakeholder surveys were conducted. We discussed with the acting manager the lack of action plans put in place as a result of surveys.

We saw records of internal audits relating to the service including care plan audits in January 2016 and

December 2015, and monthly before this. Food safety audits were conducted every other month, most recently in November 2015 in which the overall score was 99 percent. Health and safety audits were held in November 2015 and every other month, most recently scoring 93 percent. A maintenance audit was undertaken in January 2016 and approximately quarterly and there was an action plan in place. The combi-oven for the home had not been working since September 2015 and was in need of replacement. The acting manager was aware of this.

The trustees had visited the home following concerns about cleanliness on 14 February 2016, after which improvements were put in place including group supervision of domestic staff and a new cleaning schedule.

Current records were available of gas safety and electrical installation certificates, portable appliances testing, water testing, lift and hoist servicing, fire equipment servicing and regular fire drills and call point testing. There was a business continuity plan in place for the home reviewed annually. Regular maintenance activities were recorded, including at least monthly bed rails checks and servicing and cleaning of wheelchairs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff employed by the service provider did not receive sufficiently regular supervision and appraisal, and training in a format that supported them to meet people's needs effectively. Regulation 18(2)(a)