Glenarie House Nursing Home Ltd

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Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 18 August 2015.

Glenarie House is a residential service providing care and support for people with mental health conditions. It is registered to provide nursing and personal care for a maximum of 20 adults. It is a large Victorian style house, situated in a suburb of Liverpool overlooking Newsham Park. The home is within easy reach of local shops and amenities and on a major bus route.

At the time of the inspection the location was providing services for 20 people.

A registered manager was not in post. The current acting manager is in the process of making an application to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 were sufficient numbers of staff available to meet the needs of each person living at the home. There was a programme of staff training available, which included topics relevant to the needs of the people using the service. Staff were recruited subject to satisfactory references and appropriate checks being completed.

Staff were knowledgeable about the people who lived at the home. People told us that they felt safe living at the home.

The emergency call system was not readily accessible to some people living at the home. We have asked the provider to review access to the system in each room.

We looked at some aspects of fire safety in the home. People living at the home did not have personal emergency evacuation plans in place. Two fire doors in the location did not close fully. These were repaired before the end of the inspection. Staff were not required to sign to confirm that they had completed regular safety checks around the building. The provider was asked to introduce a system to ensure that checks had been completed.

Systems were in place for people living in the home, their relatives and staff to raise concerns. Evidence of appropriate and timely responses to issues raised was provided. The provider shared documents which demonstrated that they had listened to and acted on concerns and complaints.

The location had a system for the ordering, storage, administration and disposal of medication and conducted regular audits and checks. Medication was administered in accordance with this system. The location did not have detailed support plans for people who were receiving administration of PRN (as required) medication.

We were told that six people were on standard Deprivation of Liberty Safeguards (DoLS) authorisations. CQC was notified of one of these authorisations in the previous twelve months. The provider was advised to review the requirement to notify CQC of these authorisations as a matter of urgency.

We saw that staff sought people's consent before providing routine support or care. People living at the home had a mental capacity assessment completed and reviewed as part of the care planning process. Assessments were in place for specific decisions.

Individual dietary requirements were met through the production of personalised menus. This was documented in care files.

People had access to a range of primary health care and specialist services, such as GPs, dentists and mental health teams.

People were supported with dignity and respect throughout the inspection. Staff spoke to them before providing care and checked that people understood what this meant. Staff demonstrated awareness of the needs of the people and interacted with them in a professional, caring and courteous manner.

Each person was supported to be as independent as possible through a process of positive risk taking. Appropriately detailed risk-assessments supported this process.

People had private space within the service and staff were respectful of this when engaging with them.

Relatives and friends were free to visit the service without any obvious restriction.

Systems were in place to encourage people to discuss any concerns with staff. Changes to care plans demonstrated that the provider had responded to people's preferences and changing needs.

Care files were inconsistently structured and contained current and out of date information. This meant that staff may have difficulty in accessing important information and guidance efficiently.

Some areas of the accommodation had been recently decorated. There was evidence that bedrooms had been personalised.

All staff spoke positively about the influence of the management team and its leadership.

The service had systems in place to monitor and support quality assurance.

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.

Staff were required to check the smoking room in the basement every thirty minutes as a minimum, but records of these checks were not made.

Pull cords for the emergency call system were missing and some beds were located away from the call button.

Each person was supported to be as independent as possible through a process of positive risk taking. Appropriately detailed risk-assessments supported this process.

Staff were appropriately trained and delivered care in a manner which minimised the risk of bullying, harassment and harm to the people living at the home.

People told us that they felt safe living at the home. Their relatives told us that they believed people were safe living at the home.

Procedures for the storage and administration of medication were robust.

Is the service effective?

Good

The service was effective.

Staff knew and understood the care needs of each person living at the home.

Staff performance was addressed through supervision, annual appraisal and disciplinary procedures.

Staff understood their duties and knew how to access support and guidance when required.

Staff communicated well with people and engaged with them when providing care. This meant that people understood what care was being provided and could refuse if they wished.

People were supported to maintain good health through regular contact with external healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff demonstrated care and respect in all interactions with people who lived at the home.

People were involved in the regular reviews of their care and their views and preferences were used to develop care plans.

Summary of findings

Staff treated people with dignity and recognised their right to privacy and choice.

People were supported to access specialist advice and advocacy services as required.

Is the service responsive?

Good

The service was responsive.

Care and support was delivered in accordance with individualised care plans in a non-intrusive way. Support was responsive to the needs of people living at the home and promoted their independence.

People were supported to follow their own interests and activities.

People living at the home were able to raise concerns through direct contact with staff and managers and via the resident meetings.

People living at the home were consulted about changes in the service and their views were used to inform the running of the home.

Is the service well-led?

Requires improvement

The service was not always well-led.

A registered manager was not in place although the application process had been started.

Notifications to CQC regarding Deprivation of Liberty Safeguards were not completed.

The acting manager was aware of the day to day operations and culture of the home. They were knowledgeable about each of the people living at the home and their care needs.

Staff were motivated to support people living at the home and to deliver improvements in personal and team performance.

The location had a wide-range of quality assurance and safety systems in place. These included systematic checks on care plans, emergency equipment, health and safety and infection control. Records indicated that recent checks had been completed with the exception of the thirty minute building safety check.

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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 18 August 2015 and was unannounced.

An adult social care inspector and an expert by experience with an understanding of the needs of people living in residential care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had not been requested to complete 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 any improvements they plan to make.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the home and their staff. We also spent time looking at records, including five care records, five staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted social care professionals who have involvement with the service to ask for their views.

On the day of our inspection we spoke with five people living at the home. We also spoke to two relatives on the telephone. We spoke with the provider, the acting manager, the senior nurse and four other staff.

Requires improvement

Is the service safe?

Our findings

We asked people living at the home whether they felt safe. One person told us, "I'm okay here, I'm well looked after. There's a relaxing atmosphere. I'm safe, I don't feel threatened." Another person said, "They look after me well. I'm comfortable, safe and secure."

We spoke with the relatives of people living at the home. One relative said, "[relative] is safe and well looked after. It's the ideal place for them."

The building had an emergency-call system to allow people living at the home to call for assistance from their bedrooms. We found that pull-cords were missing in some bedrooms and that beds were positioned away from call-buttons. This meant that people would have difficulty calling for assistance if they had fallen or were unable to reach the call-button. We asked the provider to review the accessibility of the emergency call system in each room. The provider confirmed that this had been done.

These findings are a breach of Regulation 12(2)(e) HSCA 2008 (Regulated Activities) Regulations 2014.

People were protected from bullying, harassment and avoidable harm, because staff were trained in relevant topics and applied this training in the delivery of care. The training included courses in equality and diversity and mental health. Staff had a good understanding of the needs and behaviours of the people living at the home. They used this knowledge to monitor behaviours and intervened at an early stage where necessary to avoid any harm. Staff were trained in adult safeguarding and demonstrated an understanding of processes when questioned.

We spoke with staff to establish their understanding of the needs of the people living at the home. The acting manager told us that everyone living at the home had a mental health condition. They told us that some of the people also had learning disabilities. They said that each person had an individual care plan that described their condition and their needs in relation to care and support.

We saw five care plans which were detailed and included evidence of regular review. We told the provider that some of the files containing the care plans also contained information which was out of date. This would make it difficult for new staff to access important information in an efficient way. The provider agreed to review the files and remove any out of date records.

Each person living at the home had a risk screening tool and an individual risk assessment in their care file. Risk assessments were reviewed as part of the care plan review process. This review was undertaken every three months. Plans were in place to minimise the risks identified. Some of the risk assessments were not sufficiently detailed. This meant that staff may not have sufficient information to manage all risks effectively. The provider told us that people living at the home were involved in decisions about positive risk taking.

Accidents and incidents were recorded as part of daily records. These records were reviewed by senior staff, but there was no process in place to identify patterns or learn from previous incidents. This meant that accidents and incidents were more likely to re-occur because causes and preventative measures were not formally considered.

We asked about the use of restraint in the home. The provider told us that restraint was not used in the service and that their focus was on early intervention and de-escalation techniques. One member of staff told us that they were not aware of restraint being used since they started working at the location.

We walked around the building and identified two fire doors that did not fully close. This meant that they would not be effective in preventing the spread of fire. The provider instructed a maintenance person to check the doors and ensure that they closed fully. The maintenance person reported back during the inspection to confirm that this had been done.

The provider had a fire alarm system in place and extinguishers at appropriate points throughout the building. The fire alarm was regularly tested. They had a pack of information to provide to emergency services in the event of a fire. This pack contained a fire evacuation plan, floor plans and the location of extinguishers. The fire evacuation plan was last reviewed in January 2015. Fire drills took place regularly.

Requires improvement

Is the service safe?

Although there was a general evacuation plan people living at the home did not have personal emergency evacuation plans (PEEP) in place. This meant that they may be at additional risk in the event of a fire. The provider agreed to produce a PEEP for each person living at the home.

People living at the home who smoked were restricted to two areas. One area was to the rear of the building in the garden. The other area was in the basement of the building and was out of view of staff. This meant that staff would be unlikely to observe an outbreak of fire in this area. The room was appropriately furnished to reduce the risk of combustion. The provider required staff to monitor smoking in the basement, but did not record these checks. This meant that there was no means of establishing if they had been completed. We advised the provider to introduce these records and confirm that this had been done. The provider confirmed that this action had been completed.

Staff were aware of whistle blowing and how to report concerns. One member of staff told us, "If something wasn't right I would ring Careline (local authority) or CQC. I wouldn't think twice about it." The senior nurse told us that the location had no issues with whistle blowing, and they were confident that everyone would know what to do.

There were three care staff on duty, plus an acting manager, a senior nurse, a chef and a cleaner. This reduced to one nurse and one carer after 8:00 pm. This meant that people's access to staff for care or activities would be restricted in the evenings. The provider told us that staffing levels were regularly reviewed and were currently sufficient to meet people's needs and maintain their safety. None of the people that we spoke to expressed concern about the availability of staff in the evenings. A member of staff told us, "Staffing levels are okay. They're safe."

Staff were skilled and experienced in mental health and had been recruited following a robust process. Staff files contained a minimum of two references and evidence of a disclosure and barring service (DBS) check being secured before the person started work. A DBS check is a method for checking the suitability of people to work with vulnerable adults.

We checked the provider's approach to the storage and administration of medication. The medication was stored in the clinical room. The room was lockable and specifically allocated for the storage of medication. We looked at the medication administration record (MAR) for four people. They included a picture of each person and any special administration instructions.

Medicine that required refrigeration was stored correctly and daily fridge temperatures were recorded and signed for. We were advised that one of the people currently living in the home was prescribed a controlled drug. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Legislation. The controlled drug was stored safely in a lockable cabinet within a larger lockable cabinet. There were separate storage facilities for homely remedies, topical medicines (creams) and medication which was to be returned to the pharmacy. Medicine audits were completed monthly by a nominated nurse and followed a detailed audit template. We saw that any issues identified were checked again the next month.

We were told that none of the people currently living at the home required covert medicine. Giving medicine covertly means medicine is disguised in food or drink so the person is not aware that they are receiving it.

Some people were prescribed medicines only when they needed it (often referred to as PRN medicine). Staff were able to describe for us how they identified when people needed the medicine, usually for pain relief or when they were distressed. People did not have a PRN administration plan. This meant that staff might not know what signs to look out for and when to administer PRN medication. We discussed this with the senior nurse who agreed that this may present a risk if nurses were unfamiliar with the person. They agreed to add further detail to the relevant administration plans.

We found a copy of the British National Formulary (BNF) from 2011. This meant that staff did not have ready access to important current information about the medication that people were taking. The senior nurse agreed to order a copy of the latest edition of the BNF and to remove the old copy.

Good

Is the service effective?

Our findings

Staff communicated effectively with people living at the home and their relatives. One person living at the home said, "They keep my family informed with what's going on. They're very supportive." We saw that staff spoke to people throughout the inspection to check on their wellbeing, to encourage activity and to explain what they were doing. A relative told us, "They keep me in the picture. They always let me know if there's anything wrong."

Staff were required to complete a programme of training and to refresh this training a minimum of every three years. Induction training was completed by staff working at the location. Other training was facilitated by external organisations. Records were maintained on a spreadsheet which indicated when training had taken place. The majority of staff training was completed in January 2015. Staff were either registered on, or had completed, nationally accredited training at level two or above in health and social care. Some staff had completed additional accredited training in mental health topics. This meant that they had more specialist knowledge relating to the needs of people living at the home. One member of staff told us, "[The administrator] oversees the training. Everyone has an induction course that covers health and safety and fire regulations, then there's lots of shadowing. Only when everyone thinks they're ready will the new starter be allowed to be on their own."

Staff performance was addressed through supervision, annual appraisal and disciplinary procedures. One member of staff told us that they had received their annual appraisal and had supervision every three months. The records that we saw recorded that regular supervision sessions and annual appraisals were conducted in addition to team meetings.

We were told that six people were on standard Deprivation of Liberty Safeguards (DoLS) authorisations. DoLS is part of the Mental Capacity Act (MCA) 2005. The MCA is a piece of legislation which covers England and Wales. It provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. DoLS provides legal protection for vulnerable people who are, or may become, deprived of their liberty in a hospital or care home.

People living at the home had a mental capacity assessment completed and reviewed as part of the care planning process. Assessments were in place for specific decisions. One example we saw related to restricted alcohol intake where a best-interests decision had been made with the involvement of the person. Not all staff had been trained in the MCA. The provider told us that this would be reviewed and the appropriate courses booked.

Staff demonstrated a good understanding of the needs of the people they supported and they made a contribution to the development and review of care and support plans. Daily records were maintained to ensure that care and support plans were delivered by staff and to record any changes or other important information about the person.

Thirteen people living at the home had the capacity to withhold their consent to care. Best-interest meetings had been held for those who lacked capacity in this area. Four people living at the home shared two large bedrooms. We found no formal evidence in care records that their consent had been sought in relation to sharing or that the arrangement had been reviewed. We spoke to two of the four people who told us that they liked sharing. The provider told us that these arrangements would be formally reviewed in-line with the MCA.

We saw staff engage with people in a manner that clearly explained what they were doing. We saw people living at the home refuse aspects of care. Staff took time to explain the importance of their care and encourage them to participate. This was particularly evident during lunchtime when a person declined to eat the meal provided. Staff explained the importance of eating and offered alternatives to the meal. The person requested and was given an alternative meal which they ate.

People told us that they enjoyed the food and drinks available at the home. One person told us, "The food's okay. I don't go hungry." Another person said, "[The chef] is a good cook. There's always food and I enjoyed my lunch." The cook was an experienced chef and had produced a balanced four weekly menu which offered choice. One person had a vegetarian menu prepared specifically for them. The menu was clearly displayed in the dining room. Mealtimes were set, but we were told that people could request food and drinks at any time of day. The dining room was adequate for the number of people living at the home. A relative told us, "The food's very good. You can get snacks and things as well."

Good

Is the service effective?

People were supported to maintain good health by staff. Health checks were undertaken on a regular basis and staff were vigilant in monitoring general health and indications of pain. Appointments were made with the involvement and consent of the person and staff accompanied them where appropriate. The location promoted healthy activities and offered support to reduce smoking and alcohol consumption. Pre-admission assessments were detailed and included medical histories. There was evidence that further assessments were undertaken following admission. There was evidence in the care files that people had regular access to primary health care services including, GP's, dentists, mental health services and screening services.

The design of the building meant that it was initially difficult to navigate and was poorly lit in places. Some areas had been recently decorated. Bedrooms were clearly numbered, but other signage was limited. This meant that people who were new to the service and unfamiliar with the home would have difficulty finding their way around. There was some evidence that bedrooms had been personalised by the introduction of personal items and equipment.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with people in a manner that demonstrated care, understanding and compassion. Staff knew each person well and were able to identify their care needs in detail. One person living at the home said, "The staff are very helpful and care for me. I get on with all of my staff. They're very attentive. I feel as though I'm treated quite respectfully." Another person told us, "I feel like they're my friends as well as carers."

A relative told us, "I think it's great here, they're all marvellous. [Relative] knows the staff and has a laugh with them." Another relative said, "[relative] gets on well with staff and other residents. They [staff] know them all, they're all very friendly."

Staff were able to explain the importance of privacy, dignity, choice and human rights in relation to the people living at the home. The observations completed during the inspection indicated strongly that staff acted in accordance with these principles. We observed a member of staff entering a person's room. The person was feeling unwell and had decided to stay in bed. The staff member knocked gently before entering and then asked if the person needed anything. The staff member then explained that the person might come out of their room to use the toilet and would be wearing their nightwear so it would be better if we moved to a different area of the building to preserve their dignity. We also observed one member of staff who was rolling cigarettes for one of the people living at the home. They explained that although the person understood the potential for smoking to damage their health, they still wished to smoke. The person was unable to roll their own cigarettes and so the staff member did it for them.

We saw that people were involved in their own care on a day to day basis and at the point where care was formally reviewed. One person living at the home told us, "My [relative] visits and we have day to day chats with staff about how they look after me." Care files contained evidence that people were actively involved in the delivery of their care and that their views and preferences were acted on. People were encouraged to explore choice as part of their care and to become more independent. Some people had been supported to move on to alternative accommodation in the past. The provider told us that this was dependent on improvements in the person's mental health and the availability of suitable accommodation.

People were given information in a way that they understood. We saw staff discussing the menu and activities with individuals. Written information was available in the form of notices and letters. There was limited evidence of pictures and alternative forms of communication being used. This meant that people with learning disabilities or different communication needs did not always understand the written information that was provided. The provider said they would address this.

Confidential information was stored securely and staff told us that they understood the need to maintain confidentiality at the home. Each person had a nominated family member to discuss matters relating to their relative's care. We were told that discussions took place with the involvement of the person in a private setting.

One person had been supported to access specialist advocacy services in addition to their family member's involvement. The other people living at the home had been assessed as not requiring advocacy services. All of the people living at the home had been involved in external reviews of their care on an annual basis. One file that we saw indicated that this review was overdue. The provider told us that they did not dictate the schedule of these reviews, but would ask for a date to be agreed.

Relatives and friends were free to visit or contact the home at any time. We saw evidence of regular contact with, and visits by, relatives. Relatives spoke positively about the home and the quality of care and communication.

People were supported to access the community and activities with relatives where their risk assessments indicated.

Good

Is the service responsive?

Our findings

Care and support was delivered in accordance with individualised care plans in a non-intrusive way. It was responsive to the needs of people living at the home and promoted their independence. People's life stories and interests were recorded in their care files. People were supported to follow their own interests and activities. One person told us, "I go out for a drink every day at six o'clock. I meet friends there [local pub]. I know everyone there." Another person said, "I get up and go to bed when I want. I watch telly. Yesterday we read poems." Other activities included; a trip to York races, painting sessions and a monthly service delivered by a local minister. One person was a volunteer minibus escort with a school.

People contributed to the assessment process and the planning of care. The delivery of care was personalised and respected people's views and preferences. Care needs were documented and reviewed on a regular basis. We saw evidence in care files that these reviews led to changes in the delivery of care. One member of staff told us, "We're expected to read the care plans for every [person]. We'll also have meetings if necessary to discuss particular issues for people living at the home."

We saw that support for equality and diversity was evident in the planning and delivery of care. People were supported to access specialist advice and independent advocacy. This meant that they were not restricted by the knowledge available from within the staff team and could discuss matters which they may not wish to discuss with staff or relatives.

The provider maintained a record of compliments, concerns and complaints. We saw that complaints were filed with a record of actions and a detailed written response to the complainant. A member of staff told us that they supported people to make complaints by assisting them with the completion of any forms. This meant that people could comment on matters that were important to them regardless of their communication needs. We saw that a copy of the complaints procedure was displayed on a notice board by the front door. The procedure contained information on who complaints should be directed to and how to do this.

People living at the home were able to raise concerns through direct contact with staff and managers and via the resident meetings. The last resident meeting was recorded in June 2015. There was evidence that people's views had been used to develop new activities.

Relatives were encouraged to give feedback through regular contact with staff and the distribution of customer satisfaction questionnaires. The last questionnaires were distributed in February 2015. They invited relatives to comment on the quality of care, food and activities. The majority of the responses were very positive.

People living at the home were consulted about changes in the service and their views were used to inform outcomes. The provider had recently decided to install satellite television services in the home and wanted people to decide which channels should be prioritised. A member of staff told us, "When the owners decided to get the [satellite] television package, they asked the residents what should make up the package. Quiz shows were very popular and the sports of course."

Requires improvement

Is the service well-led?

Our findings

On the day of the inspection the staff team was being led by the senior nurse. The registered manager had left the location in April 2015. The acting manager was new to the post and was undertaking a programme of training to prepare them for the role and for subsequent registration with CQC.

We found that the Care Quality Commission had not been notified of people who were placed on DoLS authorisations. This is a requirement under the Health and Social Care Act 2008 Registration) Regulations 2014. We told the provider that they needed to review requirements in relation to notifications and monitor performance in this area. Other notifications had been submitted in accordance with the relevant regulations.

The acting manager and one of the proprietors arrived shortly after the inspection began. The acting manager was on a scheduled day off and left before the end of the inspection. The senior nurse and proprietor responded to questions in the absence of the acting manager.

People living at the home and the staff on duty were open and engaged in conversation with the inspection team. Their views were honestly and fairly expressed and were free from any obvious influence. One person living at the home said, "I've got no complaints. If I had any, I've got a tendency to speak my mind. There's nothing stopping me complaining and my [relative] would open their mouth as well." A member of staff told us, "We [people living at the home and staff] all feel part of the same team. I'd feel comfortable in questioning things." This demonstrated that the management team were open to questioning and challenges from people living at the home and staff.

The location had a statement of purpose which outlined the visions and values of the service and contained important information for anyone living at the home. This had been reviewed in April 2015. Staff were unclear in describing some aspects of the home's purpose. One member of staff said, "Staff are here to give the best quality of life. This is a home for life, but it depends on the individual."

Managers were very aware of the day to day operations and culture of the home. They were knowledgeable about each of the people living at the home and their care needs. We observed them interacting with people and their staff in a positive and open manner and issuing clear instructions where required. They were honest regarding any issues raised during the inspection and responded appropriately.

A member of staff told us, "I feel quite confident in the [acting] manager. They seem quite fair. They're doing all the training courses that we have to do, not just the management ones." They also said, "It's not just the managers, the owners are very hands-on as well. They know who you are."

The staff that we spoke with were extremely positive about the location and the leadership of the management team. They were motivated to support people living at the home and to deliver improvements in personal and team performance. Staff understood their duties and knew how to access support and guidance when required.

The management team and the proprietor demonstrated an understanding of their roles in leading the team and developing the location. Where areas for improvement were identified during the inspection they responded in a positive, professional and timely manner.

The location had a comprehensive set of policies and procedures in place. We looked in detail at those relating to recruitment, the management of complaints and quality assurance. We saw evidence that staff and management actions were undertaken in accordance with these policies.

The location had a wide-range of quality assurance and safety systems in place. These included systematic checks on care plans, emergency equipment, health and safety and infection control. All of the systems recorded that recent checks had been completed. External organisations were used to check the safety and compliance of emergency equipment. The most recent checks were completed in August 2015. This meant that the location was not wholly reliant on internal resources and had responded to findings from both internal and external audits.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(e) Access to the emergency call system was restricted in some rooms.