Orders of St John Care Trust

OSJCT Henry Cornish Care Centre

Inspection report

Rockhill Farm Court
Chipping Norton
Oxfordshire
OX7 5AU

www.osjct.co.uk

Date of inspection visit: 6 November 2014
Date of publication: 08/01/2015

Ratings

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

Overall summary

We inspected Henry Cornish Care Centre & Intermediate Care Unit on 6 November 2014. This was an unannounced inspection. The previous inspection of this service was carried out in November 2013. The service was found to be meeting all of the standards inspected at that time.

Henry Cornish Care Centre is a residential care home run by the Order of St Johns Care Trust and provides a home for 36 older adults. In addition to this there is a 14 bedded Intermediate Care Unit (ICU) within the site. Intermediate care services are provided to people to help them avoid going into hospital unnecessarily or to help them be as independent as possible after discharge from hospital.

Summary of findings

People in the ICU did not always experience care that was responsive. This was because accurate and comprehensive information about people's care had not always been recorded. Care records in the residential home were completed to a high standard.

There was a registered manager in post at the service. 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. The registered manager was also registered to oversee the ICU, however Oxfordshire Health had taken over the running and management of the in ICU and there were plans in progress to register the ICU separately from the home. Day to day management of the ICU was carried out by a ward manager and Matron.

Although the registered manager was not at the service on the day of our inspection, it continued to run smoothly. A senior manager from the organisation arrived mid-morning to support the staff through the inspection. The registered manager was clearly organised and any documents we required in relation to the management or running of the service were easily located and well presented in an organised way. Staff and visiting health professionals spoke about the registered manager in a complimentary way. They told us they were approachable, open, supportive and professional.

The atmosphere in the home was pleasant and people were cared for in a calm, relaxed and comfortable environment. Although staff were busy, they did not rush people. People told us that staff attended them promptly when required. Staff were caring and supported people in a friendly, respectful and dignified way. Systems were in place to ensure people were kept safe. People were encouraged to be as active and independent as they could be in their day to day lives. There was a positive culture at the home and staff understood and displayed the values of the organisation.

People in the ICU had a tailored rehabilitation plan to meet their specific needs. People in the ICU and residential home were supported to maintain their physical and mental health. A range of other professionals were involved in people's care to ensure their needs were met. Visiting health professionals praised the level of care provided to people.

The home had effective quality assurance systems in place and the registered manager and staff strived to continually improve the service.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people we found these had been legally authorised.

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?

Good

The service was safe. Systems were in place to ensure people were safe. These included identifying and managing risk to people and the environment as well as appropriate staffing levels and recruitment processes.

People were protected from the risk of abuse because staff were knowledgeable about the procedures in place to recognise and respond to abuse.

Medicines were stored and managed safely and there were arrangements in place to keep the home clean and hygienic.

Is the service effective?

Good

The service was effective. Staff received the training and support they needed to care for people.

People were involved in the planning of their care and were supported by staff who acted within the requirements of the law. This included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to maintain their independence, stay healthy and eat and drink enough. Other health and social care professionals were involved in supporting people to ensure their needs were met.

Is the service caring?

Outstanding

The service was caring. People were cared for in a dignified way and staff treated people with respect and were caring, friendly and supportive.

People's choices, likes, dislikes and preferences were respected. People chose where they wanted to spend their time.

People had expressed their end of life wishes and this had been recorded.

Is the service responsive?

Requires Improvement

The service was not completely responsive to people using the intermediate care unit. Care plans in the intermediate care centre did not always provide instruction to staff on how to support people.

In the residential unit care records were completed and maintained to a high standard.

People were supported to lead active lives. There was a choice of activities and regular entertainment on offer.

Summary of findings

Is the service well-led?

Good

People benefited from a service that was well led. There was a positive culture where people felt included and their views were sought. Staff told us they felt supported and the registered manager and other senior staff were approachable.

The quality of the service was regularly reviewed. Where shortfalls had been identified, actions had been taken to improve the service.

Feedback received from health and social care professionals praised the level of service offered to people.

OSJCT Henry Cornish Care Centre

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 6 November 2014. It was unannounced. 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.

At the time of the inspection there were 36 people living at the care home and a further 13 people receiving care in the intermediate care unit.

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 the service 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.

Prior to our visit we reviewed the information we held about the home and intermediate care unit. This included notifications, which is information about important events which the service is required to send us by law. We also contacted and received feedback from eight health and social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people in the residential and intermediate care unit. We looked around the home and observed the way staff interacted with people. We spoke with 14 people and five people's relatives. We also spoke with the ward manager and matron of the intermediate care centre, a registered nurse, the care leader, seven care workers, a housekeeper and the chef.

We looked at records, which included 10 people's care records, the medication administration records (MAR) for all people at the home and four staff files. We also looked at records relating to the management of the home and reviewed feedback from people who had used the service.

Good

Is the service safe?

Our findings

People told us they felt safe and supported by staff. Comments included, "Yes I definitely feel safe." and "I feel nice and safe, my daughter can come in whenever she likes to." A relative said, "I know [name of relative] is safe and very well looked after." One person told us they felt safe because they knew staff would come quickly when they called for help. They said, "Yes, I feel safe here. I only have to ring the bell." People told us and we observed call bells were answered promptly. One person said, "They [staff] are very quick coming when I ring." Some people were unable to use a call bell. Staff had identified the risks associated with not having a call bell, for each person, and there was a plan in place for managing those risks.

Staff told us they had received training in safeguarding people, and we saw certificates on staff files which confirmed this. Care and ancillary staff had good knowledge of the provider's whistleblowing and safeguarding procedures. They knew how to report any safeguarding concerns to the manager or area manager. Staff also knew how to protect people in the event of a suspicion or allegation of abuse, which included notifying the local authority and Care Quality Commission (CQC). The manager had recently raised a safeguarding alert appropriately for a person where a risk to their safety had been identified. Immediate steps were taken by the home to ensure the safety of the person.

Care plans identified risks to people's health and welfare. Risk assessments were reviewed monthly, or before if any changes had been identified. For example, one person had been identified as being at risk of developing pressure ulcers; they had specialist equipment in place to prevent skin damage. A body map was maintained and this helped staff to understand where the risks to the person's skin were.

There were risk assessments in place to address the risks associated with some people's choices or preferences. For example, one person had expressed a wish not to have their drinks thickened in line with professional recommendations as they wanted a "normal cup of tea". Care staff had worked with other health care professionals, the person who had the right to make and capacity to make this decision and their family to ensure they were aware of all of the risks associated with not having thickened fluids. Conversations and decisions had been documented and care plans and risk assessments gave staff directions on how to care for this person and what action to take if the person choked.

One person liked to fill their own hot water bottle. They had a risk assessment and management plan in place to ensure they were supported to be independent whilst being as safe as possible.

Relevant checks had been completed before staff worked unsupervised at the home. These included employment references disclosure and barring checks. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. Care homes should have checks in place to ensure that nurses have maintained their nurse registration. Although this had not been done, the administrator carried out these checks during the inspection. They then set up a system to ensure this was monitored.

People told us they felt the home was "a little short staffed" and "could be a bit short" however, they said staff were "still very quick to respond" and "there were always staff to help them when needed." Staff told us there were enough staff on duty to meet people's needs. We observed care throughout the home and saw that care workers did not rush people during care tasks. Although care workers were busy there was a calm and pleasant atmosphere throughout the home. Staff told us agency workers were not regularly used in the home because existing staff covered for sickness and annual leave when required. They said this was to make sure that people were supported and cared for by care staff who knew them and understood their needs. The number of staff needed to safely meet people's needs was determined by the manager using the provider's dependency tool.

Medicines were stored and administered safely. Staff told us they had been trained in administering medicines and we saw their competency had been assessed. We observed staff administering medicines; staff supported people to take their medicines in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) charts were completed to show when medication had been given or if not taken the reason why. Some medicines must not be given with grapefruit juice or cranberry juice because they

Good

Is the service safe?

affect how a medicine works. Staff were able to tell us which people should not be given these juices and we saw a list of people on these medicines was displayed in the kitchen.

There were arrangements in place to deal with foreseeable emergencies. There was emergency lighting in place. There were plans for managing each person's needs in the event of a power failure. Each person had an emergency evacuation plan for use in the event of a fire. Emergency plans and contact numbers were prominently displayed in the hallway.

We saw that effective measures were in place to ensure the home was clean. Both junior and senior staff were involved in infection control audits so that the importance of infection control was understood at all levels. Records showed that actions needed as a result of these audits were taken promptly.

Good

Is the service effective?

Our findings

People felt supported by competent staff. One person said "they know what to do and are good at their jobs." A relative said, "We feel confident X is in good hands." Staff told us about the training they had undertaken and how this helped them meet the needs of the people they supported. For example, training in dementia care. Staff said the training was "very good." and "makes you see and do things differently."

Newly appointed care staff went through an induction period. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to help ensure staff were safe and sufficiently skilled to carry out their roles before working independently. The induction formed part of a six month probationary period, so the manager could assess staff's competency and suitability to work in the home over a longer period of time.

Staff were supported to improve the quality of care they delivered to people through the supervision and appraisal process. Staff told us they received an annual appraisal and regular one to one supervision where they could discuss the needs of people in the home and any training and development they might wish to follow.

Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people we found these had been legally authorised.

Staff understood their responsibilities under the Mental Capacity Act 2005. We saw this in action. For example, some people required bed rails to keep that safe in bed at night. This form of equipment can be used as restraint. Staff had followed good practice guidance by carrying out, and recording, best interest decision making processes. We saw this type of decision making was specific to each person and each decision as they should be.

Staff supported people to stay healthy and people's care records described the support they required to manage their health needs. People were referred for specialist advice and we saw evidence this advice was followed.

The GP visited weekly or before if required. Health and social care professionals told us "care staff are person centred and approachable" and "care staff know the residents well". Professionals also told us peoples' changing needs were identified to them and "our advice is always followed." Details of any professional visits were seen in each person's care record, with information on outcomes and changes to treatment if needed. Records showed that people had regular access to other healthcare professionals such as, chiropodists, opticians and dentists.

We saw from peoples' care files that each person had an initial nutritional assessment when they were admitted to the home. The chef showed us how this information was communicated to the catering staff. We saw completed 'advice to chef' forms which included relevant information about the person's needs and preferences, allergies and any speech and language therapy assessments. These forms were updated as required when needs changed. Charts which provided detailed information about each person's needs and preferences were discreetly displayed in kitchens and dining rooms. Cultural information was also included, for example, one person's faith meant that they did not eat pork or pork products.

We looked at the care records for one person who had been assessed as at risk of choking. They had been seen by a speech and language therapist. Their care plan and risk assessments reflected the recommendations made. These included thickening fluids and having a soft diet. We observed this person have a soft diet and staff thickening drinks appropriately during lunch time.

People enjoyed the food served at the home. They said, "Food is good and there's a good choice." and "The cooking is really very good and they provide the very best. You can have whatever you want to each day and at any time of day or night." and "Meals are excellent with a first course and puddings." Alternatives were available for people who wanted something different from the menu options. For example, one person asked for and was given chicken soup at lunch time. Snacks and drinks were available to people throughout the day, which included cake, biscuits, crisps and jugs of orange and lemon squash and water. Hot and cold drinks were regularly offered by care staff.

Some people needed additional support and this was provided. For example, people who were at risk of losing weight. Where appropriate, malnutrition universal screening tool (MUST) charts were accurately maintained. We looked at five MUST charts for people who had been identified as at risk of malnutrition and saw that all five

Good

Is the service effective?

people were maintaining their weight. We saw people were weighed monthly and weights were consistently recorded. We saw that another person had not been eating well and when they had lost weight was referred to the GP and dietician. The dietician's recommendations included having fortified drinks and monitoring the person's weight weekly. We observed this person being assisted with fortified drinks. They were having their food and fluid intake monitored. We saw they were weighed weekly and had begun to regain some of the weight they had lost.

Mealtimes were relaxed and unhurried. People who needed assistance to eat were supported in a respectful and dignified manner. We observed how one person who staff told us was often reluctant to eat was encouraged to go the dining room at lunch time. A care worker sang with them as they moved to the dining room which the person clearly enjoyed. They sat with them at the table, chatted to them in a friendly way including other people sitting with them in the conversation, kept them focused on their meal and encouraged them to eat. This person and other people at the table were supported to have a relaxed and sociable mealtime which they appeared to enjoy.

Outstanding ☆

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. Comments from people included, "they treat me well and are very caring", "I am looked after very well", "they [staff] are kind people and good people". A relative said, "Staff are never miserable or impatient. We come very regularly and we are very comfortable that dad is here".

One of the care staff told us the values of the home were "to make sure people are happy and cared for". Other staff also spoke to us about this value. Housekeeping staff told us, "People are well cared for." and "People are all are treated equally and fairly." Other staff comments included "I'd be happy to have a relative live here. We give care and compassion", "We all look after each other" and "The residents look out for each other." A senior member of the team told us, "The staff team has such a caring nature. When I watch them I'm so proud of them."

Housekeeping staff took an interest in what people were doing and chatted with them whilst they went about their work. Care staff supported people in a way that was unhurried. They spoke to people with respect and chatted and laughed with them. One person told us, "The girls are smashing and like a bit of banter." Another person said, "I have nothing but praise for the whole place, staff are kind and fun."

We observed two care workers assisting people from the lounge to the dining room at lunch time. Staff knew how to support each person in the way they wanted. Some people could manage once helped from their chair whilst others needed support with walking to the dining room. We saw the care workers were gentle and reassuring when supporting people.

We observed care staff supported people with their personal care discretely and in ways which upheld and promoted their privacy and dignity. A relative told us "They look after my relative in a very dignified way. They have always said they are very comfortable here". Care and housekeeping staff knocked on people's doors before entering and addressed people with their preferred name.

People's preferences were respected. For example, one person liked to have a pot of tea rather than a cup, and we saw that this was provided. One person had chosen to stay in bed during the morning. They told us this was because the fireworks the previous evening had kept them awake.

Another person told us told us that they spent their day as they wished, with staff support when needed. They said, "Staff come in and help me wash. They bring my breakfast in and I have a doze in the chair. I get myself ready for bed." Another person told us "I don't like showers so they always help me with a bath instead."

Care staff described to us how they made sure people had choice. One said, "We never assume, we always ask what people would like such as getting up times or if people want to stay in bed they do. One lady likes to soak in the bath, so she does." Another said, "I'm working with [name]. We give them more time so that they get into the right frame of mind to make choices."

We heard staff ask people where they wanted to spend their time and observed people being assisted to their bedrooms or other areas of the home when they wanted. One person told us "I go outside in the garden when the weather allows but I don't go to the lounge too much. I like my sunny room with a view over the courtyard and flowers." Some doors had locks on them that needed a code to open. People told us they had been given the code so that they could move about the home freely.

We saw that one person found it difficult to communicate verbally. We observed when staff spoke with this person they maintained eye contact and used body language to communicate. Another person had written instructions for staff on how to best support them because they found it difficult to speak. We saw that these instructions were clearly recorded on their care plan.

Staff understood how people with dementia may communicate their feelings through their behaviour. One person 'walked with purpose' around the home. (This is a term used for people with dementia who feel compelled to walk about). Care staff had identified that the person did this when they were looking for the toilet. Care staff knew what this meant and ensured that the person was given the support when they needed it.

People on the ICU were cared for by staff who understood that although people may want to get home they may be anxious about leaving the unit. Staff encouraged, reassured and supported people in rebuilding their self-care skills.

No one was receiving end of life care at the time of the inspection. People were involved in decisions about their end of life care. One person told us they had been able to discuss their preferences with the manager and their family

Outstanding ☆

Is the service caring?

and “had gone through and agreed their end of life wishes which were in their care plan.” We saw conversations with people had been recorded which showed people had been involved in planning their care. For example, their preferred place of death and preferences for undertakers. Where ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) documentation was in place we saw this had been discussed with the person and their representatives. A summary of the conversation was recorded and people had been given time to think about all of their decisions and discuss them with their family. This meant that people were given information and time in order to make any decisions.

Requires Improvement

Is the service responsive?

Our findings

We reviewed people's care planning documentation and care records. A care plan is a document which gives direction and guidance to staff about a person's individual care needs. Care plans in the intermediate care centre (ICU) did not always reflect peoples care needs. For example, one person had lost a significant amount of weight prior to being admitted to the unit. Staff were providing nutritional supplements and were monitoring their food and fluid intake. Staff told us this was because "they were concerned about their weight loss." They had a document titled "Eating and drinking care plan" in their care records but this had not been completed and was blank. There was no mention anywhere else in this person's record of their nutritional needs. A person had specialist equipment in relation to their bladder and bowel. Staff on duty were able to describe how this person should be supported but these needs were not reflected in their care plans. They had a document titled "Elimination plan" in their record but this had not been filled in and was blank.

Some people had care plans but they had not been reviewed or updated during their admission to the ICU. For example, the target length of stay in the ICU was 28 days. We looked at the care record for a person who had been in the unit for 28 days. When they were admitted the 'management of pain' had been identified as a care need. They had a care plan for pain which stated 'for X to be as comfortable as possible.' We heard the nurse ask this person about their pain and if they wanted pain relieving medicine. Their care plan had not been reviewed or updated during their admission.

This person had also been identified as at risk of malnutrition and dehydration. They had a care plan in place and appropriate action had been taken to involve other professionals in their care in relation to this. We observed they were supported and encouraged to eat and drink. Staff had started monitoring food and fluid intake, however records were not always completed and did not include enough detail to inform staff if adequate nutrition and hydration had been taken. For example, there were no records of any food or drink being consumed on four dates, on one date only a meal at breakfast time had been recorded and there were many entries where "tea" or "water" was recorded without documenting the actual amount consumed. This meant that records could not be used to determine if this person was eating and drinking enough and this information would not be available to inform the care provided by other visiting health professionals.

We spoke with the matron and the unit manager about the issues we had found with the records. They showed us an audit which identified similar issues. This had been completed the week before our inspection. The manager was in the process of developing an action plan to deal with the issues.

In the residential unit care records were completed and maintained to a high standard. They contained detailed and personalised assessments and the care plans were based on people's assessed needs. Care plans were cross-referenced with other care plans. For example, breathing with mobility and skin integrity with nutrition and mobility. The head of care told us, "If staff are reading care plans it is important that they know how one need affects other areas, so that is why we cross-reference them". Each area of the care plans described the desired outcome of the care provided. We saw that independence was promoted, as what people were able to do for themselves was described; for example, "X can wash themself but help is needed with washing their back". We spoke with this person, who confirmed care staff helped with this.

People told us that before they came to live at the home or stay in the intermediate care unit their needs had been assessed to ensure that that they could be met. We saw care records that confirmed this.

On one person's care file we saw how an incident involving behaviour that challenged was recorded as a 'distress reaction'. We saw that staff had analysed this incident and updated the guidance in their care plan to ensure their needs continued to be met.

People told us it was there were lots of activities and they were supported to lead active lifestyles. Comments included "there's always lots going on", "We are encouraged to use the garden when the weather is good" and "I have been gardening we planted some seeds and looked after the pots in the summer. We have access to the gardens on our own and sometimes I do some artwork". Arrangements had been made for people to attend the local church on Sundays. One person told us outside entertainers were brought into the home. They said, "they get some singers in

Requires Improvement

Is the service responsive?

and some are very good." We observed people playing dominoes and a group of ladies sitting in the "knitting corner" chatting and knitting. Relatives told us it was "open house for visitors."

People confirmed they were encouraged to be as independent as possible and told us how they were involved in everyday activities such as washing up or preparing drinks for guests. One person was a keen painter. They told us how they had been helped to arrange their room to make it suitable for painting and displaying their work.

The service had received 69 compliments and four complaints in the last year. People knew how to make a complaint and the provider had a complaints policy in place. The manager checked if people were satisfied with the outcome of their complaint. Feedback from people and their relatives about the quality of the service was sought.

For example, a residents and relatives meeting was held monthly and people being discharged from ICU were encouraged to complete a feedback form. Systems were in place to ensure that any actions identified following feedback or complaints were implemented and also to learn how the service could improve the quality of care for all people. For example, the manager of the ICU had noticed that there were a number of people commenting that they did not feel they had been adequately orientated to the unit when they were admitted. Team meeting minutes showed staff were asked to consider how this experience could be improved for people. We saw staff had decided to trial some laminated flash cards containing information about the unit that staff could go through and then leave with people. We spoke with the ward clerk who was in the process of making the flash cards and they told us they hoped to have them in use by the end of the month.

Good

Is the service well-led?

Our findings

The service was well led by a registered manager and team of senior support workers and nurses. 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.

The ICU had a ward manager and matron in place and there were plans in progress to register the ICU separately from the home. In order to maintain service quality and governance the ward manager and registered manager met on a weekly basis. The ward manager also provided a daily report for the registered manager which covered areas such as any incidents, admissions to the unit, patient concerns and staffing.

Staff spoke positively about the team and the leadership in both the residential unit and ICU. They described the registered manager and other senior staff as being supportive and approachable. Staff described a culture that was open with good communication systems in place. Staff were confident that the management team and organisation would support them if they used the whistleblowing policy.

On the day of our inspection the registered manager was not at work. The home continued to run smoothly, led by other staff within the home. Staff told us they could always contact the registered manager or an on call manager for advice and support if the registered manager was not working in the home.

There was a positive culture where people felt included and their views were sought. Staff understood the values and ethos of both the residential home and the ICU. Staff were empowered to speak out and raise concerns or make suggestions to improve the service. They felt valued and were confident concerns would be taken seriously.

Regular meetings took place between people, their relatives, the manager or other senior staff and any other professionals involved in their care. A relative confirmed the registered manager attended the care reviews and they had regular contact with the registered manager throughout the year. Relatives told us they were always made to feel welcome when visiting and could speak with the registered manager or senior staff at any time.

Feedback received from health and social care professionals prior to inspection praised the level of service offered to people; their relationship with the registered manager and how they and other members of the management team communicated with them. One told us "they are both keen to deliver best practice and operate in a helpful and transparent way, engaging with stakeholders to learn from mistakes and develop the services in a positive way."

There were a range of quality monitoring systems in place to review the care and treatment offered at the home. These included a range of clinical and health and safety audits. Audits were not just seen as the remit of the registered manager and other staff such as the chef and senior care workers also completed them. We saw evidence of how the quality monitoring systems were used to make improvements to the home. For example, We saw reports of the monthly kitchen audits carried out by the chef during 2014. Areas audited included cleanliness of the food preparation and storage areas. The reports showed that where issues were identified such as staff failing to clean to the required standard, the matter was dealt with promptly.

There was a clear procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented on a standardised form and actions were recorded. Incident forms were checked and audited to identify any risks or what changes might be required to make improvements for people who used the service.

We saw that people were actively encouraged to provide feedback through a satisfaction survey and the results of these as well as the quality assurance systems such as audits and accidents and incidents were compared with other locations within the Orders of St John Care Trust. The management team reviewed the results and took steps to maintain and improve the homes performance.

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.

This section is primarily information for the provider

Enforcement actions

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