Counticare Limited

Richardson Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 27 and 29 September 2016 and was unannounced. Richardson Court provides accommodation and support for up to six people who may have a learning disability or autistic spectrum disorder. Some people display behaviour which may challenge others. At the time of the inspection six people were living at the service.

Richardson Court was last inspected on 19 August 2015 where two breaches of our regulations were identified, an overall rating of requires improvement was given at that inspection. The provider had resolved the issues raised at the previous inspection which were no longer a concern at this inspection.

Each person had a single room; some rooms had en-suite facilities. People had access to shared bathrooms, kitchen, laundry room, dining room, and a large communal lounge. There was a well maintained, secure garden and outside area that people could access freely. There was off street parking within the grounds.

The service did not have a registered manager in post. 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 had de-registered with the Commission in February 2016; the provider had appointed a manager to manage the service in March 2016. They had submitted an application to register with the Care Quality Commission (CQC) at the time of our inspection. The manager was present throughout the inspection.

Risks to people were not always managed safely, this put people at potential risk of harm. Paint had been left in a person's bedroom and portable, electric fires used in peoples rooms were unguarded and had not been risk assessed.

Regular supervisions had not been established for all staff, the manager had not checked the competency of a staff member who worked alone.

There were enough staff to meet people's immediate needs, agency staff and the manager covered any gaps in the rota. The provider was in the process of recruiting more staff.

Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment.

The manager had good oversight of monitoring people's support needs. People had behavioural guidelines in their care plans to help staff manage incidents. When incidents occurred the manager and staff discussed how things could change to improve outcomes for people.

Staff had a good understanding of how to keep people safe. Contact names and numbers of who to contact

within the service and outside of the service were available should concerns about people's safety need to be raised.

There were safe processes for storing, administering and returning medicines. Medicines were administered by trained staff. Regular audits were conducted on medicines to check errors had not occurred.

Staff had appropriate training and experience to support people with their individual needs and demonstrated a clear understanding of the people who lived there.

New staff underwent an induction which prepared them for their role and did not work unsupervised until assessed as competent to do so. Safe and robust recruitment process were in place to ensure people were supported by appropriately checked staff.

The service was good at responding to people who needed help to manage their health needs. People were supported to access outside health professionals.

The manager had a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). People were offered advocacy services and the service had taken the appropriate steps to meet the requirements of the legislation.

People had choice around their food and drink and could choose alternative meal options when they wished. People with individual dietary requirements were catered for and advice was sought from healthcare professionals to help people to manage this.

Staff demonstrated caring attitudes towards people and showed concern for people's welfare. People's choices were respected and staff spent time engaging people in communication in their preferred way. When people required to be supported with their anxieties staff did this in a patient and compassionate manner. People felt confident and comfortable in their home and staff were easily approachable.

People were supported in a person centred and individual way. People's care files were written in an easy read format which included pictures to help people understand its content. Each person had a key worker who regularly reviewed if the person's current needs were being met or had changed.

People were helped to make complaints and staff supported people who were unable to use the easy read complaints policy by understanding what their body language meant if they were unhappy.

The service had been without a registered manager since February 2016 which is a requirement of the provider's registration with the Commission; the manager had been in post since March 2016 and had applied for their registration with the Commission.

The manager understood the key challenges of the service and had started to make changes to improve the service people received. Staff said they felt well supported by the manager and commented that the service had improved since their appointment.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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?

Requires Improvement

The service was not always safe.

Risks to people were not always managed safely, this put people at potential risk of harm.

There were enough staff to meet people's needs.

Accidents and incidents were recorded and audited to identify patterns.

People were protected from abuse and staff understood the processes for raising concerns about people's safety.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Regular supervisions and competency checks had not been established for all staff.

Staff had received the training they required to be able to support people with their needs.

People's health needs were responded to promptly and people were supported to access professional healthcare when they required this.

People were involved in making decisions about their food and drink.

Is the service caring?

Good

The service was caring.

Staff spoke to people in a kind, patient and engaging way. There was a good rapport between people, staff and the manager.

People's bedrooms were decorated in a personal way.

People were treated with respect and dignity.

Staff demonstrated they understood people well and supported them with their interests.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed, informative and person centred. Documents were written in an easy read format with pictures to help people understand the information.

People were offered varied activities to meet their individual needs and interests.

People were supported to raise concerns, and processes were in place to recognise and respond when people were unhappy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A manager was not registered with the Commission.

Staff felt they could go to the manager for guidance and support and were positive about the future of the service.

People's feedback was sought so improvements to the service could be made.

Staff demonstrated positive attitudes to their work and it was evident the manager was trying to improve the service people received.

Internal audits were conducted to identify shortfalls and improve the care people received.

Richardson Court

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.

This inspection took place on the 27 and 29 September 2016 and was unannounced. The inspection was conducted by one inspector. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with three staff, one agency worker, the manager and a visiting registered manager of another service within the providers group. Before the inspection we received feedback from two healthcare professionals. After the inspection we received feedback from one healthcare professional and two relatives. We also spoke to one relative and two staff. People were not able to express their views clearly due to their limited communication. We observed interactions between staff and people. We looked at a variety of documents including four people's support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, training records, medicine administration records, and quality assurance information. The provider was asked to send us some information after the inspection which they did in a timely manner.

Requires Improvement

Is the service safe?

Our findings

A relative said, "When we have visited we have been pleased, the care is first class and the home is nice. (Relative) is always happy when we see them, I have no concerns".

Risks to people were not always managed safely, this put people at potential risk of harm. Three large pots of decorating paint and gloss (which can be harmful if ingested) had been left in a person's bedroom. Although they were relocated immediately when this was pointed out to the manager, it could have potentially harmed people if they had accessed it. Portable heaters were being used in people's rooms. Portable heaters would be hot to touch and were unguarded. This posed a danger to people who frequently touched objects. A risk assessment had not been put in place to reduce the risk of people being hurt by the unguarded heaters.

The provider had failed to do all that was reasonably practicable to mitigate risks. Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff to meet people's immediate needs. Records confirmed there were three staff on duty throughout the day and during the night there was one wake night staff. One person had recently been allocated one to one hours which were covered by an additional staff member. Agency staff were frequently used to cover gaps in the rota and the manager helped cover shifts if short staffed. There was a list of emergency on call managers that staff could contact if they required any support or guidance when the manager was unavailable. The provider was in the process of recruiting to fill vacancies within the staff team.

Recruitment processes were in place to protect people: Employment gaps had been explored, references and photographic identification obtained and Disclosure and Barring Services (DBS) checks made. These checks identified if prospective staff had a criminal record or were barred from working with adults. Other checks made prior to new staff beginning work included references, health and appropriate identification checks to ensure staff were suitable and of good character. The manager conducted interviews with applicants, and the rest of the recruitment process was completed by head office.

People had their own individual risk assessments according to their needs. Risk assessments identified risk areas, hazards associated with the task, potential outcomes, and actions to reduce the risk and impact of harm to people. Areas identified as significant risks were individual to each person's own needs. Risk assessments included areas such as bathing and personal care, going out and travel, eating and drinking, skin management, managing finances and personal belongings and displaying challenging behaviour. Risk assessments were kept current to reflect people's changing needs. People had individual personal emergency evacuation plans (PEEPs) that staff could follow to ensure people were supported to leave the service in the most appropriate way in the event of a fire. Fire evacuation drills were conducted to observe how people's PEEPs would be put into practice.

The manager had good oversight of monitoring people's behaviour and recorded incidents on monitoring

sheets and a recording chart. People had behavioural guidelines in their care plans to help staff manage incidents. Incidents were audited to identify patterns and the manager used this as an opportunity to learn and improve outcomes for people. Accidents and incidents could be logged on the provider's internal computer system which allowed for reoccurring patterns and trends to be monitored and explored further. The manager discussed incidents in team meetings to improve the way the staff team worked. Staff were asked to feedback if they had found improved ways of working with people or had identified any new triggers to people's behaviours. In July 2016 a healthcare professional had conducted a consultation session with staff around the management of a person behaviour which had become more challenging to support. A traffic light system was introduced which described how staff could respond proactively, actively and reactively depending on the intensity of behaviour displayed. This increased staff understanding and confidence when helping support the person.

Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment. This included weekly and monthly infection control audits, checks on electrical installation, fire alarm system, fire extinguishers, emergency lighting, portable appliances and Door guards (Door guards are a safety device which will automatically close open doors if the sound of the fire alarm is activated). The provider could be assured by making these checks that the premises and equipment were in good working order and safe for purpose.

People were protected from abuse and staff understood the processes for raising concerns about people's safety. One staff member said, "I've had safeguarding e-learning and I know I could call the Care Quality Commission, safeguarding or use the internal whistleblowing procedure". A safeguarding policy was available for staff to refer to as well as a safeguarding flow chart detailing contacts and numbers which could be called to report concerns. The provider had an internal whistle blowing number staff could use should they need to raise any concerns. Safeguarding was discussed during team meetings to further improve knowledge, understanding and confidence staff had in this important area.

There were safe processes for storing, administering and returning medicines. Four people stored their medicine securely in their bedroom and two peoples medicine was stored in the medicine room. All people required support to take their medicine safely. People had individual medicine profiles around how they liked their medicines to be administered and staff that administered medicines were trained to do so. The manager or team leader was responsible for ordering and returning stocks of medicine. The manager competency checked any staff that dispensed medicines to ensure good practice continued. Daily and monthly audits were conducted by the team leader and manager, this ensured all medicine was accounted for and safely administered. Regular audits monitored errors, temperature checks to ensure safe storage of medicines had been completed, occasional medicine (PRN) protocols were up to date and body maps were correctly completed if people required creams or lotions to specific parts of their body.

Requires Improvement

Is the service effective?

Our findings

A Healthcare professional said, "In my experience, the home have responded well to changing client's needs, the manager made the referral to Speech and Language Therapy following a choking incident. They have followed Speech and Language Therapy guidelines carefully and they have telephoned to check when they are unsure if particular foods are safe following the implementation of a modified diet".

At the previous inspection we found areas of concern around the environment. Radiator covers were missing from all but one radiator leaving the people who use the service at risk from harm. The house was generally clean; however, there were several areas around the service in need of maintenance and repair which had not been responded to in a timely way. This had made effective cleaning difficult for staff. Equipment was broken in some communal and personal areas. Although there was a maintenance folder with job sheets documented, numerous repairs had not been completed. This meant that people were left with unsafe equipment and premises and robust infection control processes could not be met. The provider had resolved the issues raised at the previous inspection which were no longer a concern at this inspection.

Supervisions were either formal or observational. The provider's policy stated staff should have a minimum of six supervisions per year using a combination of supervision types. Direct supervision were one to one with the manager, team supervisions were held collectively as a group and observational supervisions were used to competency check staff. Prior to the manager taking up post all forms of supervision meetings had lapsed for staff. The manager had improved the completion of formal supervisions although some staff had not received a direct supervision for some time. Direct supervisions were valuable as they allowed staff to discuss any issues they may have privately with the manager.

One staff member who lone worked at night had only received one supervision in 2016 which was a team supervision. The manager said, "I agree there is a gap here and I need to be more certain of their competency. Although I have not had a supervision with them I have talked to them by telephone". Another two staff had not received any direct supervisions in 2016 although they had received team or observational supervision. This is an area which requires improvement.

One person occasionally refused to get up from their bed and presented behaviours with could challenge others. The person had seen the dietician and implemented guidelines stated that staff should ensure the person received sufficient food intake as they were at risk from malnutrition. We observed staff take the person meals and snacks throughout our visit. Staff recorded what the person had eaten during the day, how much of their meal they had eaten and if they had been offered any snacks so the person's health could be monitored and action could be taken if concerns were identified. The person was prescribed additional meal replacement drinks by their doctor which was recorded on their medication record. We pointed out to the manager that a total amount of calorie intake to aim for would be useful for staff so they could be certain the person had received the right daily amount.

A staff member said, "The manager is more on top of the training which is better, they will chase staff up to make sure they have completed it". Another staff member said, "The manager has improved the training

and most staff are up to date". All staff completed mandatory training in the form of face to face or e-learning to equip them with the skills needed to carry out their roles effectively. Mandatory training included; medicine administration, fire safety, food safety, health and safety, first aid, infection control, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), and safeguarding people. Additional training was offered to staff in specialised areas such as epilepsy, nutrition and techniques used to breakaway from people who may be displaying physically challenging behaviour. Staff were able to describe how they supported people with their individual needs including behaviour which could challenge others, supporting people who had epilepsy and supporting people with specific dietary requirements.

Staff were encouraged to gain qualifications in health and social care. Six staff had obtained a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level two or above and six staff were in the process of completing this. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

New staff were taken through a four day induction programme to prepare them for working with people. Staff shadowed other staff for two weeks as well as completing the provider's in house induction workbook as part of their induction when beginning employment with the service. The workbook was signed off by a senior or the manager; staff also completed training which was essential to their role. New staff were completing The Care Certificate to supplement the providers own induction. The Care Certificate was introduced in April 2015 and are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

People were offered choice with their food and drink; menus were available in the kitchen with pictures to help people recognise the choices available. Staff frequently asked people if they wanted drinks and offered them hot and cold choices. A staff member said, "There are alternatives if people don't want certain meals. People are offered choice, but not too much choice which could be overwhelming". People who had specialist requirements around their meals such as pureed food were catered for and guidelines were displayed in the kitchen to remind staff of the appropriate meals people should be offered. Referrals were made to the appropriate health specialist when people were identified as being at risk when eating and drinking. People's cultural dietary requirements were catered for.

People were supported well to monitor their health care requirements. Three people had epilepsy which could result in them having seizures; protocols were in place should the use of rescue medicine be necessary. Staff demonstrated a good understanding of the action they should take if a person had a seizure although seizures were infrequent. People were supported to attend health appointments including check-ups at the optician, chiropody, dentist, dietician, and doctors to review their medicines. Referrals had been made to other healthcare professionals such as the psychologist to support people if their behaviour changed. A staff member said, "We had a behaviour expert come in and it was really good. It made us recognise the person's facial expressions better and introduced a new traffic light system to help support with their behaviour. It gave me more confidence".

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 are called the Deprivation of Liberty Safeguards (DoLS).

Four deprivation of liberty safeguards (DoLS) authorisations had been granted and two further applications had been made. The Commission had been informed of the applications which had been granted, which meant the service was complying with the legal requirements expected. The manager demonstrated a clear understanding of the process that must be followed if people were deemed to lack capacity to make their own decisions and capacity assessments had been documented for less complex decisions in peoples care files.

Good

Is the service caring?

Our findings

A healthcare professional said, "The staff I have worked with appear to care for their clients, speak to them kindly and act in their best interests".

We observed people moving freely around the service and outside grounds. The back door was open and staff told us it always was so that people could move freely around their home when they wanted, some people were walking around outside. This meant that people's right to freedom and choice was being observed. This had specific positive outcomes for one person who could go out to the garden voluntarily to de-escalate their own behaviour. There was a secure front gate at the end of the long driveway to keep people safe from crossing the road unsupported.

Sensory equipment was available for people to hold and interact with which people particularly enjoyed to use. There were several shelves of various sensory objects. This included various coloured plastic balls which floated in the water, spongey shapes which could be squeezed and a bubble machine. There was information above the equipment which explained the various sensors people used and had been implemented with the input of the provider's internal behaviour specialist. One person had a board hanging on the wall in their bedroom of different textured fabrics which they could feel and touch.

People's bedrooms were decorated in a personal way and they had many objects such as personal photographs, pictures, soft toys and fairy lights to make their rooms feel homely and comfortable. People's preferences were respected, for example one person preferred to have a blanket on their bed instead of a quilt. Additional blankets were stored in a box at the end of their bed if they required additional warmth.

People were unable to tell us directly of their experiences. We were able to observe a number of examples where staff showed a caring and compassionate attitude towards people. One person sat with a staff member who asked them if they would like to go out for a coffee, the person responded in their own way and they laughed with the staff member throughout their interaction. People frequently came to the manager's office where they were welcomed and invited to join in with discussions. While dinner was being prepared all people observed what was going on, staff welcomed people and interactions between people and staff were relaxed and inclusive.

People were involved in making decisions about their care and treatment. Staff respected a person's decision not to come out of their room although they frequently checked on them to see if they had changed their mind. Staff accepted this was the person's choice and supported them to follow their own personal routine. Staff always asked for permission before entering the person's room and knocked on their door. If people needed help to make specific or complex decision they were supported to obtain advocacy services.

Staff had a good understanding of people's personal histories and backgrounds. A staff member said, "One person is able to understand another language. I go on to the internet to find translations of words and phrases. Last week we wrote a thank you card to the person's relative and wrote it both in English and the

persons other language".

Staff showed concern for people and cared about their welfare. When a person became agitated staff quickly offered support to the person and verbal reassurance to alleviate their anxieties.

Good

Is the service responsive?

Our findings

A staff member said, "I have taken (person) to the day centre this morning to do arts and crafts and have social interaction. (Other person) likes to go for drives; they used to go to the day centre but didn't get on with it".

People were supported in a person centred and individual way. In one person's bedroom a communication board was in use to support their communication. The board used PEC pictures. Picture Exchange Communication System (PECS), is an alternative way of communicating with people with autism spectrum disorder or for people who have various communicative, cognitive and physical impairments and included titles like "I feel" with various different pictorial emotions like happy, funny, okay, good. There was a morning schedule and evening schedule which encouraged the person to make choices about their day using the various pictures available. Some people had photographs of clothing on their chest of drawers and wardrobes to help them identify where their clothing was to encourage independence and choice.

People's care files were written in an easy read format which included pictures to help people understand its content. Information included a one page profile, communication information, likes, dislikes, daily routines, preferred way of receiving personal care, medication, management of health, risk assessments, guidance around food and positive behaviour support plans. The manager had been updating the care plans to improve them further and to ensure the most current information was documented. Information to guide staff to deliver person centred care was well explained. For example one person's daily routine stated, 'I like two mugs of tea before my bath', and 'When you rinse my hair I prefer it to be done with a jug, not the shower head'.

Each person had a key worker who regularly reviewed if the person's current needs were being met or had changed. Key workers checked if appointments were due, if they had been attended and if follow ups were needed. They were in charge of overseeing all aspects of the person's health and social care, this ensured good oversight of each individual person.

A staff member said, "I took (person) out for a car ride the other day and we had doughnuts. Yesterday we went to the zoo; we shall see what (person) wants to do today". During our visit all people left the service to do different activities. People went out in the homes vehicles with staff escorts. One person went to a day centre to do arts and crafts. Some people went to the zoo and beach and another person went for a drive in the vehicle and stopped at a restaurant to have lunch out.

A weekly activity plan was on the wall in the communal hallway. Each person had their own individual schedule and PECs pictures were used to help communicate the information, the information displayed on the plans reflected what people did during our visit. People were offered various recreational activities to participate in including visits to the community pop in centre where people could socialise and have a cup of coffee, country walks, swimming, bowling, food shopping, personal shopping, discos at the day centre, arts and crafts at the day centre, and horse riding. Activities such as baking and sensory baths were offered inside of the service if people chose not to go out.

The service responded to complaints appropriately and had robust systems in place; an easy read format was available for people who may need it. When concerns or complaints were made these were recorded and follow up action taken and recorded. Some people found it difficult to understand how to complain following the formal process. They relied on staff to recognise if they were unhappy about the service they were receiving by understanding their body language and other means of communicating. There were no open complaints at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

A staff member said, "The manager is very professional. They have changed everything round a lot. They are approachable".

At the previous inspection we found areas of concern round the management of the service: Although audits were undertaken there were significant shortfalls in action, particularly in relation to the environment. Maintenance of the property was not adequately being responded to in a timely way meaning some areas of the service were unsafe for people. We were unable to see if any action had been taken following the information obtained from surveys or see how the service had actively made improvements following the views from people outside of the service. The environment had improved since the previous inspection and the areas raised as a concern had been responded to and repaired. People's representatives had been sent surveys to complete and action had been taken to address any shortfalls highlighted.

The service had been without a registered manager since February 2016 which is a requirement of the provider's registration with the Commission. The manager had been in post since March 2016 and had spent time since their appointment, getting to know people and staff to work out what the main areas of improvement were. The manager divided their time between this service and another service within the same grounds. A staff member said, "The manager knows the material through and through. They give us supervision and support and have been working hard to update the care plans. They are always there if I need advice".

The manager understood the key challenges of the service and their role and had prioritised tasks to improve the service people received. They told us that improvement was needed to staff deployment and more male staff were required to support a person who preferred this. The manager planned to improve the role of the key workers further to deliver a more person centred approach to people, they said it was important to stabilise the staff team as there had been many changes over the last few months. The manager understood it would take time to embed the new direction of the service and said it was important this happened with an inclusive team approach. The manager had obtained their level three diploma in health and social care and had signed up to do their level five diploma to continue to develop their skills and knowledge set.

The manager had support from the locality manager who visited the service. They also had 'buddied up' with a registered manager form another service in the organisation for advice and support. The registered manager from the other service visited on the first day of the inspection. They said, "I give the manager support by phone or I drop in. It's good for both of us to keep up to date with current practice". There was an open and inclusive culture. During the inspection people and staff frequently came to the manager's office to talk to them and interactions were relaxed and supportive. The manager told us they felt it was important that people felt comfortable to come into the office at any time even if the door was closed.

There was good communication between staff to ensure people's daily needs were met. A Staff handover and shift planner was completed to ensure basic information was communicated. A senior staff member

was in charge of each shift and designated tasks to other staff on duty. Included on the shift planner was information about activities for the day, which staff was assigned to which persons personal care, arranged appointments, who was responsible for keys, who the designated first aider was, money handover, who took charge in the event of a fire, and cleaning tasks.

The manager notified the Care Quality Commission of any significant events that affected people. Analysis of incidents and accidents were completed regularly and other auditing of areas such as medication were completed. The provider conducted their own internal audits and completed service development plans to identify short falls and improve the quality of care people received. When audits were conducted the manager was given an action plan to work towards which was regularly reviewed by the locality manager.

The audit in July 2016 had identified that improvements were needed in areas such as medication, behaviour management, accident and incident recording and monitoring, staff training, and obtaining feedback from people, their representatives and staff. When action had been taken, this had been documented and dated on the audit to demonstrate improvement. For example behaviour management had improved as additional guidelines had been implemented with the input of a behaviour specialist, and one page profiles had been made available for each person which new staff could refer to as a quick reference. The audit found surveys had not been sent to relatives to obtain feedback and team meetings had been infrequent. The manager had improved this by sending surveys to relatives, and organising meetings with the staff team. Both actions had been achieved by the agreed timescales.

The provider had listened to, and acted on feedback, nine surveys had been sent to peoples relatives in August 2016. Following the analysis of the completed surveys improvements had been made to the activities offered to people and one person had been allocated additional one to one hours.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonable practicable to mitigate risks. Regulation 12(1)(2)(a)(b).