St George's (Liverpool) Limited

St George's Care Homes

Inspection report

Croxteth Avenue
Liscard
Wallasey
Wirral
CH44 5UL
Tel: 0151 630 6754

Date of inspection visit: 29 September 2015
Date of publication: 24/11/2015

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 29 September 2015 and was unannounced. The home is an adapted former hospital building, situated close to Liscard town centre. The home was registered to provide accommodation and nursing care for up to 60 people and 50 people were living there when we visited. The people accommodated were older people who required 24 hour support from staff. On the ground floor, care was provided for people who required general nursing or personal care. The first floor accommodated people who were living with dementia.

The home had a manager who was registered with the Care Quality Commission. 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 and associated Regulations about how the service is run. The registered manager was not at work on the day we visited.

Summary of findings

During the inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'Safe care and treatment'. You can see what action we asked the provider to take at the end of this report.

During the day of our visit we saw that there were enough staff on duty and people did not have to wait for staff to attend to them. The rotas we looked at confirmed that these staffing levels were maintained by using agency staff as needed. We found that safe recruitment processes had been followed before new staff were employed at the home and the required records were all in place.

We found the environment to be light, spacious and airy. Toilet and bathroom areas were clean and hygienic. Hand cleanser, paper towels and pedal bins were provided. We had some concerns regarding fire safety and referred our concerns to the fire service. Maintenance records showed that up to date certificates were in place for lifting equipment, the fire alarm system, fire extinguishers, emergency lighting, nurse call system, portable appliance testing and microwave emissions, boiler maintenance, and gas safety.

The home used an e-learning training system that included 12 subjects. We found that the training modules were not in depth. In particular, the dementia awareness training was very basic which meant that staff lacked the skills to provide care in a way that best met the needs of people living with dementia. There were induction training programmes for new care and nursing staff.

Deprivation of Liberty Safeguards (DoLS) had been applied for with respect to most of the people who lived on the first floor and some who lived on the ground floor. These were awaiting authorisation by the local authority. Applications made were for supervision, safety and being behind locked doors. We looked at a DoLS authorisation that was in place for one person and found this to be in order.

We observed many times when drinks and snacks were offered and encouraged throughout the day; these included fortified milk shakes, biscuits and cakes. We looked at weight records and noted that everyone was weighed monthly. We saw that nutrition and fluid charts were maintained for people who had lost weight and were at risk. There was also evidence of external agencies such as speech and language therapist and GP being involved and their recommendations were being followed.

We observed that staff members responded to people in a polite, well-mannered way. They were patient and supportive, and knocked on doors before entering people`s rooms. We observed family members visiting during the day with no restrictions. Staff we spoke with had a good understanding and knowledge of people`s individual care needs.

We looked at care records for six people who lived at the home. These showed that people's care and support needs were assessed and planned for and the plans were reviewed monthly. However, we were concerned that care documentation was fragmented with three different systems running concurrently.

There were no social activities taking place on the day we visited. The activities organiser had left the home and the manager was trying to recruit a replacement but was finding the post difficult to fill.

The service's complaints procedure was displayed on a wall in the entrance area. The complaints procedure was concise but provided enough information for people to be aware of who they could contact, both internally and externally, with any complaints or concerns. We found complaints records detailing three issues that had been dealt with during 2015. These showed that the manager had responded appropriately to concerns that had been raised.

We saw evidence that regular staff meetings and resident and relatives meetings took place. A significant number of satisfaction questionnaires had been circulated and returned during 2015. We saw records of a series of quality monitoring audits that were carried out. Although these systems were in place to find out people's views and to monitor the quality of the service, there was no evidence to show how the information gained was used to address any areas requiring improvement or to take the service forward.

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 entirely safe.

There were enough staff to meet people's needs and robust recruitment procedures were followed for new staff.

The environment was clean and adequately maintained but we found some concerns regarding fire safety.

Medicines were generally managed safely but we identified some issues that needed to be addressed.

Is the service effective?

Requires improvement

The service was not entirely effective.

A programme of staff training was in place but the standard of the training was very basic.

The requirements of the Mental Capacity Act had been implemented.

People received enough to eat and drink but the dining experience on the first floor was not satisfactory.

Is the service caring?

Good

The service was caring.

Staff members responded to people in a well-mannered, polite way. They were patient and supportive, and knocked on doors before entering people`s rooms.

Staff we spoke with had a good understanding and knowledge of people`s individual care needs.

Family members visited during the day with no restrictions.

Is the service responsive?

Requires improvement

The service was not entirely responsive.

Records showed that people's care and support needs were assessed and planned for and the plans were reviewed monthly. We were concerned that care documentation was fragmented with three different systems running concurrently.

There were no social activities taking place on the day we visited. The activities organiser had left the home and the manager was trying to recruit a replacement.

Records showed that the manager had responded appropriately to complaints that had been raised.

Summary of findings

Is the service well-led?

The service was not entirely well-led.

The home had a manager who was registered with CQC.

Regular staff meetings and resident and relatives meetings took place.

A significant number of satisfaction questionnaires had been circulated during 2015 and a series of quality monitoring audits were carried out.

There was no evidence to show how information from meetings, surveys and audits were used to address any areas requiring improvement or to take the service forward.

Requires improvement

St George's Care Homes

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 29 September 2015 and was unannounced. The inspection team consisted of three Adult Social Care inspectors and a specialist professional advisor (SPA). The SPA was a healthcare professional with experience in the nursing care of older people.

During the inspection we spoke with eight people who lived at the home, six visiting relatives, the clinical services manager, the administrator and 12 other members of the staff team. We looked at the care records of six people who used the service. We looked at staff records, health and safety records, medication and management records. We carried out a Short Observational Framework for Inspection (SOFI) over the lunch-time period. SOFI is a specific way of observing care to help us understand the experience of people using the service who are not able to express their views to us.

We contacted the relevant quality assurance officer at Wirral Borough Council who informed us that they currently had no concerns regarding the service.

Requires improvement

Is the service safe?

Our findings

People who lived at the home told us "I have got everything I want here, no problems and I do feel safe here." and "If you need anything you don`t wait long. The staff come over or to your room as quick as they can." Relatives told us "I don`t worry about anything when I leave here. I know the staff take good care of her." and "I don`t think he`s at any risk here and he is kept safe." A member of staff said "Part of the induction covers safeguarding and emergency procedures and then we get on-going training."

Training records we looked at showed that all except four of the staff team had done training about safeguarding, but staff members we spoke with were not fully able to describe the home's safeguarding policies and procedures. Two of the staff on duty had been supplied by a nurses' agency. They told us they had done safeguarding training and would report any concerns to the nurse in charge, the manager, or the agency. CQC records showed that the manager had sent us notifications of safeguarding incidents that occurred at the home.

We looked at staff rotas which showed there was a nurse and three care staff on duty on the ground floor and a nurse and five care staff on duty on the first floor throughout the day. One person who lived at the home required one to one support 24 hours a day and another person required one to one support 12 hours a day. At night there was one nurse and five care staff on duty. During the day of our visit we found that there were enough staff on duty and people did not have to wait for staff to attend to them.

The rotas we looked at confirmed that these staffing levels were maintained by using agency staff as needed. The senior person on duty told us they had some staff vacancies for nurses and care staff and recruitment was on-going. The senior person on duty told us that they did not receive any information about the agency staff supplied, for example what training they had done. The agency staff we spoke with said they had been shown around the home and introduced to the other staff. The agency nurse said she had been shown the medicines room and the system used.

We looked at the recruitment records for four new staff. We found that safe recruitment processes had been followed before they were employed at the home and the required records were all in place.

We undertook a tour of the building and found the environment to be light, spacious and airy. There were unpleasant odours in some areas on both floors. The bedrooms were a mix of single and double rooms with 25 rooms on the ground floor and the same number on the first floor. None of the bedrooms had en-suite facilities, but there were enough toilets and bathrooms on each floor for people to use.

On the day of the inspection, there was no hot water in the bedrooms, which had also been the case on the previous day. We were told by the maintenance person that remedial work being carried out by the plumber had required the water to be turned off and it was anticipated that the supply would be restored by the end of that day. Showers were still available, as was the hot water supply to the kitchen. We found that sluice doors were not locked, and it appeared that the keypad locks were faulty. This presented a risk to people because hazardous cleaning products were kept in these rooms.

We found some concerns regarding fire safety. Two emergency fire doors on the ground floor led to concrete steps, with no equipment apparent to enable people who were not mobile to be evacuated safely. In addition, the gate leading from one of these exits to the road was secured by a padlock. The fire safety log book we looked at showed three names entered in the training register dated September 2014 and the fire drill log showed only the names of only two members of staff entered in December 2013 and April 2015 respectively. Training records we looked at showed that no staff had done fire training within the last year and previous fire training was done by e-learning. This meant that staff may not know how to evacuate people in case of fire. We have referred our concerns to the fire service.

These issues are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'Safe care and treatment'.

Personal emergency evacuation plans were held in a "grab file" located in the first floor nurse's office. The reason we were given for this was that this was the only office which

Requires improvement

Is the service safe?

remained accessible to staff 24 hours a day. Records showed that weekly fire safety checks covering the alarm system, emergency lighting, extinguishers, doors and closers were carried out.

We looked at maintenance records and found that up to date certificates were in place for lifting equipment, the fire alarm system, fire extinguishers, emergency lighting, nurse call system, portable appliance testing and microwave emissions, boiler maintenance, and gas safety.

We observed that footplates were used on people`s wheelchairs, but bedrails were not all adequately covered to protect people from the risk of injury. Some of the bedrails had short bumpers which may not be adequate to reduce the risk of limb entrapment. Some of the bumpers were dirty and one set was ripped.

We spoke to the senior housekeeper who told us three cleaners were on duty each day throughout the week. We saw cleaning schedules, including the deep clean rota and several audits which had been carried out by the senior housekeeper. These included bathrooms, toilets and sluices, bedrooms, equipment, public areas and store cupboards, and the laundry. We looked at the toilet and bathroom areas and found them to be clean and hygienic. Hand cleanser, paper towels and pedal bins were provided. Hand washing instructions were displayed which provided a useful reminder of the required hand washing procedure. We saw that an ample amount of personal protective equipment was available and staff wore protective clothing when conducting duties. People had their own toiletries for personal use.

We visited the kitchen and found this to be clean and tidy. We discussed the daily and other cleaning schedules with the cook, who explained how they and their colleagues maintained hygiene standards in the area. We saw that the last environmental health food hygiene assessment had awarded the kitchen a 5 star rating.

The cleaner's store was tidy and well laid out. All hazardous substances were stored separately and product information was available. The provider had current protocols in place for care staff cleaning and laundry, as well as a Control of Substances Hazardous to Health (CoSHH) policy. We were informed that the senior housekeeper was the infection control lead for the home and forwarded their audits to the manager once completed. A controlled waste transfer note for both trade and clinical waste was in place.

We looked at medicines storage and recording on the ground floor. There was a locked medicines room of adequate size which was reasonably tidy. The temperature of the room and the drugs fridge were recorded on some days, but not consistently every day. There was a cabinet for storage of controlled drugs and a chart in place to record a 'daily' count of controlled drugs however this had not been completed on at least six occasions since 18 September 2015. We saw that monthly repeat medicines were signed in onto the medication administration record (MAR) sheets to indicate that a nurse had checked they were correct. However, hand-written additions to the MAR sheets were not always signed and the quantity of medication received was not recorded on the MAR sheet so that it was not possible to confirm that the correct amount was left.

We looked at records for two people who were prescribed medication to be given 'as required' to reduce anxiety. There were 'PRN Care Plans' in place, however these lacked any detail to ensure that the medication would be used consistently by the nurses. The nurse on duty told us that there was no 'covert' (hidden) administration of medication.

The SPA observed the agency nurse completing the morning medication round on the first floor. We were told this was her first shift in the home. She explained that she had worked in a number of care homes now, all did things differently, but she was familiar with the system being used at St George's. We observed that she checked to ensure she had the right person before giving the medication by asking care staff. She waited to ensure the person had taken their medication before leaving and then signing the MAR chart. We heard her ask people if they would take their medication "Would you like to take your tablets for me?" The nurse told us she was having to take time with the medicines round as she didn't know people. She had started around 9am and the morning round was completed around 11.30am. We noted that the afternoon round commenced just after 1pm and asked the nurse about this.

Requires improvement

Is the service safe?

She said she was starting with those who had their medications first to ensure that enough time had elapsed – particularly for those on pain medication such as Paracetamol.

Requires improvement

Is the service effective?

Our findings

A relative told us "I have got to say the staff do seem very well trained here – they just seem to know what people need and they are so helpful."

We looked at staff training records. These showed that the home used an e-learning training system that included 12 subjects. We found that some staff were able to complete this very quickly. For example, in one record we looked at the member of staff completed fire safety training in 15 minutes, health and safety law in 17 minutes, and dementia awareness in 20 minutes. The senior member of staff we spoke with agreed that this suggested the training modules were not in any depth. We also noted that all of the staff who completed the training about data protection, risk assessment, dementia awareness, and control of substances hazardous to health scored 100%. This suggested that the testing at the end of the module was not rigorous.

Most staff had completed training modules covering equality and diversity, first aid, health and safety, infection control, the Mental Capacity Act and safeguarding during 2014. Catering staff had done food safety training. It was recorded that 58 staff completed moving and handling of people training in 2014, however during our visit we observed an inappropriate and unsafe handling technique being used when transferring a person.

The dementia awareness training was very basic which meant that, although staff were observed to be, on the whole, well-meaning in their approach, they lacked the skills to provide care in a way that met best practice guidance for supporting people living with dementia. The clinical lead nurse told us she had a background in acute medicine within the NHS, but received support from the mental health registered nurses who were employed to work on the first floor.

There was an induction programme for new care and nursing staff. This comprised a basic two day programme followed by foundation training over to be completed over a 12 week period.

We looked at the staff supervision plan, which showed that some staff had attended up to four meetings with their supervisor during 2015. However, others had no dates recorded and others had only one date. Staff told us supervision meetings were held regularly but they were "not sure" about appraisals and we did not see any records of appraisals.

A senior member of staff told us that Deprivation of Liberty Safeguards (DoLS) had been applied for with respect to most of the people who lived on the first floor and some who lived on the ground floor. These were awaiting authorisation by the local authority. Applications made were for supervision, safety and being behind locked doors. We looked at a DoLS authorisation that was in place for one person and found this to be in order.

We heard many instances where consent was sought verbally. For example, one person required assistance to change their clothing as a result of incontinence. One member of staff tried to encourage the person to go with her to the toilet, but the person declined so the member of staff went away and asked another member of staff to try. This staff member spoke to the person saying "I think we need to change your clothes." The person looked at her, then nodded and went with the care assistant.

Two people required one to one care. We observed the staff providing this in an unobtrusive way, interacting appropriately with them, talking to them, and trying to engage with them where possible. We noted that staff were assigned for around two hours, then another member of care staff took over. This meant that staff were able to be more interactive with the person as they were not assigned for long periods of time, which could lead to the person and staff member becoming tired of each other's company.

We saw bedrails in use. These were risk assessed and consent obtained at the time of putting them into place. We could not find any on-going records of updating the risk assessments to evidence that the risk was still being managed appropriately.

A person who lived at the home told us "I think within reason, if you didn`t like something I`m sure they would cook you something different." A relative said "She does have a good appetite and when I have been here she has not left very much. She enjoys the food." We observed lunch being served on the ground floor. Twenty people were present in the dining room with three staff members in attendance at all times. People could eat in their rooms if

they preferred. We saw one staff member sitting next to a person encouraging them to eat their lunch. The staff member supported the person in a caring, dignified manner.

Lunch was a hot meal, but no alternative hot meal was observed although sandwiches were available. Staff members told us a choice of food was given but we did not observe this. Fruit and cream or yoghurt was available for sweet. Hot and cold drinks were also offered. The atmosphere was quiet with music on in the background. Staff members were patient with people and one carer supported a person with their lunch after asking for consent first. We saw another carer support a person discreetly with their personal care requirements. The carer changed the protective clothing they were wearing during the process which helped minimise the risk of any cross infection.

On the first floor, there were two dining tables in the lounge and a separate dining room. It appeared that the people who were more able ate in the dining room, whilst those in the lounge required more supervision. We spent time in both areas and found the meal service to be chaotic. No-one seemed to take the lead. The heated food trolley was initially sited in the dining room and then moved into corridor. In the lounge, only one person was assisted to eat and the others were left to their own devices as care staff came in and out of the room. Some were prompted to eat by different staff at different times. Some people sat in armchairs around the lounge to eat their meal. We did not hear if this was by choice, but a care assistant told us that it was.

The people in the dining room were all provided with corned beef hash. We did not hear any choices offered. We noticed that one person would have benefitted from a plate guard as they struggled to keep the food on their plate. We saw care staff taking plates of food to people's rooms with no trays being used. There were no cold drinks available on the table but tea was offered and readily accepted. We observed many times when drinks and snacks were offered and encouraged throughout the day; these included fortified milk shakes, biscuits and cakes.

We looked at weight records for people living on the first floor and noted that everyone was weighed monthly. We saw that nutrition and fluid charts were maintained for people who had lost weight and were at risk. There was also evidence of external agencies such as speech and language therapist and GP being involved and their recommendations being followed. We noted that one person had coeliac disease and a care plan was in place to ensure a gluten free diet.

We did not find that the environment met good practice guidance for supporting people living with dementia. Appropriate signage was not in place on all bathroom and toilet doors and bedroom door personalisation, for example family pictures, were seen on some doors but not all and would have been beneficial. We observed one person who was confused and had entered another person`s room by mistake. When we took them back to their room, the person recognised it because of family pictures on display. Picture menus, rather than written, for those people in the more advanced stages of dementia would have proved valuable and reflected a person centred approach to providing care. The provider may benefit from looking at current good practice guidelines related to dementia environments.

We found the first floor dining room to be unwelcoming with not even a picture on the wall. The décor was tired with many holes in the walls and no window dressing. There was nothing to stimulate someone living with dementia to want to eat in the room. Plates were white, the meal was served with white bread and margarine put on the same plate as the corned beef hash, this made it difficult to visualise the bread as it blended into the colour of the plate.

The ground floor dining room had been refurbished and improved. The garden and terrace area was used by several people during our visit. The ground floor lounge had chairs in rows and was not at all homely. The bedrooms were a mix of being tastefully decorated, with personal items on some walls, to stark white coloured walls, with chipped paint in places, which would have benefitted from a coat of paint. The maintenance person told us they were in the process of doing this work whenever a room became available, or at the request of a resident or their relatives. We were shown a room which was in the process of being redecorated, with two paint colours being used. We noted that adjustable beds were provided except where the person or their representative had installed a divan bed.

Good

Is the service caring?

Our findings

People who lived at the home told us “All the carers are very attentive. If you need anything you only need to ask.”; “They (carers) are very patient with everyone. When they get a chance they will sit down and chat with you.”; “I have got a couple of really nice friends. I did not know them when I came in but we always sit together now.” A relative said “I am happy with everything and mum`s happy too – I think the staff have a hard job and they do their best.” A member of staff said “I feel I know what people like. [Person’s name] likes to walk a lot so we take turns and in the afternoon he likes some bed-rest before his evening meal.”

The SPA found “Most staff were kind and caring in their approach to people. They clearly knew the service users well and used this knowledge to stimulate conversation. One service user had dolls in her arms at mealtime. Care staff did not try to take these away, even though the lady was struggling to hold them and eat. A care assistant asked if she could “feed the baby” which enabled the person to eat her meal. I heard a care assistant reassuring a lady that her family will be in later “They come every day, be here soon.”’

We observed that staff members responded to people in a polite well-mannered,way. They were patient and supportive, and knocked on doors before entering people`s rooms. We observed family members visiting during the day with no restrictions. In general, people who required support with personal care appeared smart and well-dressed, however we noticed that a lot of female residents had no stockings or tights.

Some bedrooms were shared by two people and had a built-in privacy screen. Some people had personalised their bedrooms with pictures, ornaments and small items of furniture.

We saw that there was a copy of the ‘service user guide’ in each bedroom and this provided comprehensive information written in an accessible style. The information included contact details for the service provider. In the main entrance area there was information about how to make a complaint and about reporting safeguarding concerns. There were also leaflets about the ‘CareAware’ helpline and advocacy service.

Requires improvement

Is the service responsive?

Our findings

People told us "There`s no set times for going to bed – I go when I feel tired – no one tells me to go."; "We used to do a few things, games and things but not lately – don`t know why."; "If I needed to complain about anything I would see one of the carers or maybe the manager."

Visitors told us "They just don`t do anything with him. Every time we come in he`s sitting in his room. He was so active and loved to go out but he never does. He does absolutely nothing." and "They do contact us if they need to."

Staff members told us "If anyone made a serious complaint to me I would note everything that was said and pass it on to the manager."; "We did have an activities co-ordinator until she left six weeks ago so the staff fill in when they can. We have interviewed two people recently but they weren`t suitable."; "When we do the care plan reviews and assessments we try and involve the residents and families if possible. Sometimes it`s not."

Staff spoken with had a good understanding and knowledge of people`s individual care needs. They told us they received information at staff handovers at shift change-over times. The nurse on duty on the ground floor told us that nobody was currently receiving end of life care and nobody living at the home had a pressure ulcer. One person chose to spend all of their time in bed as they were more comfortable there. Five people were in bed on the morning we visited; some were having a lie in; some enjoyed an occasional day in bed, for example a person who was 100 years old; one person had leg oedema and felt more comfortable in bed. They were repositioned by staff every two hours as needed.

We looked at care records for six people who lived at the home. These showed that people's care and support needs were assessed and planned for and the plans were reviewed monthly. Records showed that people received services from external healthcare professionals and were supported to attend hospital and clinic appointments as needed. Some of the people who lived on the first floor were supported by NHS mental health professionals.

The main care records were on an electronic system. They were not easily seen as person centred, although they were individualised. Unfortunately, not all records were on the electronic system, for example wound care records, so these had to be viewed in a separately held individual file for the person. We found that having two different records made triangulation of risk, care planning, and external agency involvement was not easy to follow. In addition, on the ground floor we found that people had care notes written by the care staff and kept in their individual bedrooms. These included a sheet for communication with relatives. There was some useful personal information about people in these records, however we were concerned that three different systems of documentation ran concurrently.

There were no social activities taking place on the day we visited. The activities organiser had left the home and the manager was trying to recruit a replacement but was finding the post difficult to fill. We were told that musical entertainers visited from time to time and care staff did quizzes and bingo in the ground floor lounge when they had time. We saw that, in the ground floor lounge, some people were reading newspapers, some were watching TV, some were chatting to each other, and others were asleep.

The service's complaints procedure was displayed on a wall in the entrance area. The complaints procedure was concise but provided enough information for people to be aware of who they could contact, both internally and externally, with any complaints or concerns. We found complaints records detailing three issues that had been dealt with during 2015. These showed that the manager had responded appropriately to concerns that had been raised.

Requires improvement

Is the service well-led?

Our findings

A person who lived at the home told us "The manager is off I think but we see her a lot. We can talk to any of the carers." Members of staff said "The manager is very firm but very fair and you can talk to her anytime you need to."; "I enjoy working here and the staff and the manager are very helpful and supportive." ; "We have meetings now and again and we always discuss the residents – I mean that`s what we're all about." A visiting professional commented "Going back a while it was not good here but I have got to say big improvements have been made and it`s a lot better now."

The home had a manager who was registered with CQC, but unfortunately the manager was not at work on the day we visited so we were unable to meet her. The manager was not a registered nurse so a clinical lead nurse had been appointed. Staff we spoke with said the manager was easy to talk to and approachable. CQC records showed that the manager was aware of the notifications that were required to be sent to the Commission.

We saw that regular staff meetings took place. These included general staff meetings, of which five had been held during 2015. Items discussed included education, standards of care, and professionalism. Two education and training meetings had taken place where items such as training needs, planned sessions, and induction packs were discussed. In addition, six meetings for the nursing staff had been held during the year to date. Topics included bedroom audits, staff development, medication, and an end of life register.

We also saw that five resident and relatives meeting had been held during 2015 where items such as the summer fair were discussed. We saw that these meetings were typically attended by three people who lived at the home and six relatives.

We saw that a significant number of satisfaction questionnaires had been circulated during 2015. The areas covered included autonomy and choice, community contact; complaints, ethos, hygiene and the infection control, meals and mealtimes, money, protection, quality assurance and residents' rights.

In the March /April 2015 period, 45 responses were received, the vast majority suggesting they were very happy with the standards within the home. One person commented they had issues with offensive odours and food service, as well as not enough activities. Two people did not agree with the statement "I know I can handle my own financial affairs" and one person did not think there were enough opportunities for them to get out and about if they wanted to.

In the May/ June 2015 period, 38 responses were received and once again, the vast majority of comments were very favourable. One person had an issue with the emergency call system allowing them to call for help when needed and one person was not happy with the view from their room.

In the July/August 2015 period, 31 responses had been received with a high level of satisfaction noted. Two people disagreed with the statement, "I know I can handle my own financial affairs," and one person seemed to disagree with statements concerning choice. One other person did not agree that the home appeared to have an adequate number of staff.

We asked the senior member of staff on duty whether any of this valuable feedback had been analysed and were told that this had not happened, which meant that some of the information was already six months out-of-date and could potentially lead to people becoming frustrated as they may decide they were not being listened to. The last analysis of such data had been completed in March 2015.

Records showed that the home's policies and procedures had been reviewed in August 2015. These included infection control, infectious outbreaks, food hygiene, hand hygiene, untoward events (business continuity plan), health and safety, risk management, quality management, complaints, safeguarding and whistleblowing.

We saw records of a series of quality monitoring audits that were carried out. We were informed that the senior housekeeper was the infection control lead for the home and completed audits which were forwarded to the manager. We considered that, whilst these were effective hygiene audits, they did not include any clinical aspects of infection control. A monthly kitchen audit was recorded up to August 2015. A monthly fire safety audit was completed up to September 2015, however this did not identify the issues that we found during the inspection. A mattresses audit had been completed in September 2015. There were also monthly checks of people's weights, medication, wound care, meals, and falls. It was not clear what action

Requires improvement

Is the service well-led?

was taken for those people experiencing a high incidence of falls. Five care files per month had been audited in March, May, June, July and August 2015, but again it was not clear what follow up action had then been taken.

Although systems were in place to find out people's views and to monitor the quality of the service, there was no evidence to show how the information gathered was used to address any areas requiring improvement or to take the service forward.

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 **The provider had not ensured that the premises were safe.**