Lifestyle Care Management Ltd

Windmill Care Centre

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

Summary of findings

Overall summary

This inspection took place on 20, 21 and 27 February 2017. It was an unannounced visit to the service.

This was the service's first inspection since changes to its registration in November 2015.

Windmill Care Centre provides care for up to 53 older people and people with dementia, including nursing care. Forty four people were receiving care at the time of our inspection.

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. An application for registration of a manager had been withdrawn by the applicant shortly before this inspection took place.

We received positive feedback about the service. Comments from people included "I'm very happy here, I'm comfortable," "Nice and clean and always a staff member around" and "The girls do well with the activities." Relatives' comments included "We're very appreciative that they fitted him in and they've been able to maintain his level of health. This is really fantastic" and "I do feel for staff, they run a skeleton staff. I'm sure they'd want to give more time and care but staffing impacts the time they can spend, but they are faultless when they do spend time with (name of person)."

We found staff to be motivated and enthusiastic about the care they provided. They understood about person-centred care and how to safeguard people from the risk of abuse. People's needs were met in a timely way and we saw staff were caring and kind.

However, people were not protected from the risk of unsuitable workers. The home did not always use robust recruitment practices to make sure prospective staff and agency workers had the right skills, qualifications and attributes. Staff told us they felt supported but we found formal professional supervision had not been embedded at the home. We have made a recommendation for supervision to be carried out in accordance with the provider's policy.

There were safeguarding procedures and training on abuse to provide staff with the skills and knowledge to recognise and respond to safeguarding concerns. We found a lack of clarity about whether safeguarding incidents between residents needed to be reported to the local authority each time they occurred. We have made a recommendation for the service to seek clarification about this.

People had access to healthcare professionals as needed. Medicines were handled safely and given to them in accordance with their prescriptions. Risks to people's health and safety were managed well. The building was well maintained to ensure the premises were safe. We have made a recommendation for records of fire practice drills to be developed so these can be used as an opportunity for learning and improving safety.

We found the home was not always working within the principles of the Mental Capacity Act 2005. For example, copies of Lasting Power of Attorney documents had not been obtained to make sure appropriate people were consulted on residents' behalf.

People said they enjoyed the food and there had been improvement since the current chef had been at the home. Meal times were relaxed and unrushed with second helpings offered to people with good appetites and encouragement to eat given to those people who needed it. We saw some people were unable to understand the meal choices offered to them. We have made a recommendation for plated meal options to be considered, to help people make a decision about what they would like to eat.

People's needs were recorded in care plans. These had been kept up to date to reflect changes in people's needs. We have made a recommendation for information to be recorded about people's life histories, to ensure they receive person-centred care.

People were supported to take part in a range of social activities. Complaints were responded to and changes were made where appropriate.

People spoke positively about the manager. A healthcare professional told us "Since (the manager) has been in place there has been an improvement in the general care being given in the care home and a feeling of calm. He has successfully recruited more staff and improved the training of the existing staff." A person who lived at the home said "You can tell him anything you want, he's as good as gold he is." A relative told us "Since the new management, things have got better."

Monitoring took place to assess the quality of people's care. There were clear visions and values for how the service should operate and staff promoted these. For example, people told us they were treated with dignity and we saw they were given choices.

We found care records were in good order and were easily located. Other records, mainly health and safety related checks and certificates were difficult for managers to find and show us. We have made a recommendation to improve filing and storage of records.

The manager had let us know about some important events they needed to tell us about. However, we were not informed of the outcome of applications to the local authority to deprive people of their liberty or about safeguarding incidents which happened between people who lived at the home.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staff recruitment and application of the Mental Capacity Act 2005.

We also found a breach of the Care Quality Commission (Registration) Regulations 2009, as the service had not notified us of all important events.

You can see what action we told the provider to take at the back of the full version 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.

People were not protected from the risk of being supported by unsuitable workers. This was because robust recruitment procedures were not always used by the service.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures for staff to follow in the event of any abuse happening. However, incidents between residents were not always referred to the local authority safeguarding team.

People lived in premises which were well maintained. Records of fire practice drills needed development so they could be used as an opportunity for learning and improving safety.

People's medicines were handled safely and in line with good practice.

Is the service effective?

Requires Improvement

The service was not always effective.

People received care from staff who said they felt supported. However, formal supervision systems had not been embedded at the home to develop staff in their professional roles.

Decisions made on behalf of people who lacked capacity were not always made in accordance with the Mental Capacity Act 2005.

People's nutritional needs were met and they said they enjoyed their meals. Some people struggled to understand meal options; we have recommended showing plated options to help people make decisions.

People were supported by staff who had received appropriate training to meet their needs effectively.

People received the healthcare support they needed to keep healthy and well.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff protected their privacy.

People at end of life were kept comfortable and treated with compassion.

People were treated with kindness and affection by staff.

Staff managed people's distress well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's preferences and wishes were supported by staff and through care planning. However, we saw information about people's life histories had not always been sought and recorded to help ensure they received person-centred care.

There were procedures for making compliments and complaints about the service.

The service responded appropriately if people had accidents or their needs changed, to help ensure they remained independent.

People were supported to take part in activities to increase their stimulation.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The Care Quality Commission was not always told about reportable events which happened in the service. This meant we could not see what action had been taken in response to these events.

People were not always protected from the risks of poor record keeping. Some records relating to areas of health and safety were difficult to find.

People spoke highly of the manager and said they were approachable.

People's care was monitored by the provider to make sure it met people's needs safely and effectively.

Staff promoted the provider's values such as dignity, choice and privacy in the way they supported people.

Windmill 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 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 20, 21 and 27 February 2017 and was unannounced.

The inspection was carried out by one inspector. An expert by experience attended on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted healthcare professionals, for example, GPs and the local authority commissioners of the service, to seek their views about people's care.

We spoke with the manager and seven staff members. This included the clinical and non clinical deputy managers, the chef, activities organiser, nurses and care workers. We also spoke with a healthcare professional who visited the service whilst we were there. Six relatives and eight people who lived at the home told us about their experiences of the service. We sat in on a seniors' meeting for heads of department and shadowed a medicines round to observe practice.

We checked some of the required records. These included four people's care plans, 23 people's medicines records, three staff recruitment files and five staff training and development files. We also looked at checks and certificates for premises safety, monitoring of the quality of care and a sample of policies and procedures.

Some people were unable to tell us about their experiences of living at Windmill Care Centre because of their dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People were not fully protected against the risk of being supported by unsuitable workers. We found the home had not always used robust procedures when it recruited staff. In one of the personnel files we checked, we found there was no account for a five year gap in the member of staff's work history. We asked if there were other records which recorded what the person was doing during this time. The manager said there were no other records or information about this. We saw two references had been obtained for the member of staff. One referee only provided an answer to one of the questions asked; the second referee provided some limited information. Between the two references there was no information about ability, character, and conduct of the person. There was no information on the file or elsewhere to show that further attempts had been made to obtain these details from other referees the person may have been able to supply.

In a second personnel file, a gap in work history of seven years was not accounted for. There were no other records the manager could produce to show this gap had been explored with the applicant. In the third file, there was no record of a check of the member of staff's nursing qualification before they were offered employment or subsequently. This information was checked on the Nursing and Midwifery Council website during the inspection and found to be satisfactory. We advised the manager that photographs were needed to complete the staff files.

The service used agency workers to support the home. We asked to look at information to verify satisfactory checks had been carried out for two care workers by the agency. The manager and one of the deputy managers were unable to produce any information to show us they had these details before the workers started at the home or subsequently. This information needed to be sought from the agency which supplied the staff. Both agency workers had been at the home for several months without confirmation of satisfactory employment checks.

These were breaches of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information was requested from the agency about the two workers whilst we were at the home. This showed satisfactory checks had been made as well as training profiles.

People we spoke with told us they felt safe at the home. Comments included "I feel safe here" and "I've got everything I want here." Relatives told us they felt people were safe, such as "I feel she is safe here" and "I don't feel I have to come every day."

There were procedures for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had also undertaken training to be able to recognise and respond to signs of abuse. Staff told us they would report any abuse to the nurse on duty, the manager or their human resources department. One care worker said "There's no secrets here."

There was some lack of clarity around what needed to be reported to the local authority safeguarding team. We saw evidence that some safeguarding incidents were reported and handled appropriately. However, in conversation with the manager they were under the impression they did not need to refer all incidents where there had been physical altercations between people who lived at the home. They said there was a written record from the local authority about this but were unable to show us.

We recommend confirmation is sought from the local authority regarding referral of safeguarding incidents between service users.

Risk assessments had been written, to reduce the likelihood of injury or harm to people. We read assessments on people's likelihood of developing pressure damage, supporting people with moving and handling and their risk of developing malnutrition. Measures were put in place where people were assessed as being at high risk. For example, pressure relieving equipment was provided where people were at significant risk of pressure damage. We saw emergency evacuation plans had been written for each person. These documented the support and any equipment people needed in the event of emergency situations. Staff had been trained in fire safety awareness and first aid to be able to respond appropriately.

We observed there were enough staff to support people. People's needs were met in a timely way with most call bells answered promptly. We saw staff managed busy times of the day well to ensure people's needs were met, for example, at meal times. People we spoke with told us there were staff around when they needed them.

Staffing rotas were maintained and showed shifts were covered by a mix of care workers, nurses and senior staff. Staff were allocated named people to support on each shift. This helped to ensure everyone received the support they needed and that people received continuity of care during the shift.

People's medicines were managed safely. There were medicines procedures to provide guidance for staff on best practice. Staff handling medicines had received training on safe practice and had been assessed before they were permitted to administer medicines alone. People told us they received their medicines when they needed them. We saw staff maintained appropriate records to show when medicines had been given to people, which provided a proper audit trail.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the treatment rooms. When a controlled drug was administered, the records showed the signature of the person who administered the medicine and a witness signature. Regular stock checks were completed. We checked controlled drug use and records in one part of the home; this showed accurate records were maintained and safe practice was followed.

People were protected from the risk of unsafe premises. The building was well maintained. There were certificates to confirm it complied with gas and electrical safety standards. Equipment to assist people with moving had been serviced and was safe to use. A range of measures were in place to safeguard people from the risk of fire. We noticed records of fire drills did not record the time of day when the drill took place, how long it took and any issues which arose.

We recommend records of fire practice drills are developed in line with good practice and used as an opportunity to improve safety.

Requires Improvement

Is the service effective?

Our findings

Decisions made on behalf of people who lacked capacity were not always made in accordance with legislation.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found applications had been made to the local authority to deprive people of their liberty; outcomes were awaited for several applications.

We looked at records of decisions made in people's best interests. In some cases, the decision under discussion was not recorded. The MCA is quite clear is stating the decision which needs to be made must be recorded.

We noted care plan documents did not record whether people who lacked capacity had a legally appointed representative to make decisions on their behalf. Where it was considered they did have someone who had Lasting Power of Attorney, there was no copy of the legal document to confirm this. This meant the service had not satisfied itself it had consulted the right people to make decisions on residents' behalf.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care from staff who had been appropriately supported. Staff told us they felt supported and could go to their senior or the manager if they needed any advice. However, staff had not received regular supervision from their line managers. These are one to one meetings to discuss ways of working, professional development and improvements to individual performance.

The manager told us the provider's expectations were for staff to have six supervision meetings each year, two of which could be group meetings. They said supervision had only recently got underway at the home. There was a chart on the office wall with dates of when it had been carried out. For some staff the chart was blank which meant they had not received any supervision, 16 staff had had one supervision meeting and ten staff had received two or more sessions. We asked if there were planned dates booked for further supervision meetings, to help ensure a regular pattern was established for staff. The manager said this had

not been done.

We recommend supervision is planned and carried out in line with the provider's policy on supporting staff.

Appraisals had been carried out for some staff. The manager told us 26 staff had worked at the home long enough to require an annual appraisal. They said eleven appraisals had been completed so far and the remainder would be completed by mid April this year.

The training records we looked at showed a range of courses had been undertaken. These included moving and handling theory and practice, safeguarding, first aid and infection control. There were competency assessments for nurses to demonstrate and a 'holistic competency' assessment for all care staff. This was linked to the Care Certificate, to make sure staff provided care safely and effectively. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way.

We received positive feedback from healthcare professionals about how the home managed people's healthcare needs. A visiting healthcare professional said "The care is generally very good here." They told us staff followed any recommendations they made to improve people's care and they did not have any concerns. Another healthcare professional said they were "Generally very happy with the care being given there at present." They said they had been working with the home to improve communication about medical decisions and improving confidence in managing end of life care.

We saw people's care records contained information about any visits they had received from healthcare professionals and hospital appointments and the outcome of these.

We observed staff communicated effectively about people's needs. Relevant information was documented in daily notes and handover records. A daily seniors' meeting took place with all heads of department and the manager. The meeting we attended included discussion about any concerns, areas to follow up, activities and assessment of a prospective resident.

People were supported with their nutritional needs. The chef told us they were made aware of people's nutritional needs and any changes to these by staff and in the daily seniors' meetings. Care plans documented people's needs in relation to eating and drinking. Staff following guidance from the speech and language therapist regarding appropriate consistency of food and drinks. This reduced the risk of the person choking. Soft consistency and pureed meals were attractively presented, with foods blended separately to retain colour, flavour and interest for people.

People said they enjoyed the food. We asked people whether they enjoyed their meals. Comments included "The food is good here, the lunches are nice" and "Very nicely presented, it makes all the difference." Another person said "That's nice" when they tasted the cottage pie. They also said they liked the carrots served with it. A relative told us "There has been a new chef and things have improved; the flavour and different dishes."

People were offered a cooked breakfast each day as well as toast, porridge, cereals and a choice of juices and hot drinks. We saw staff offered more food where people had good appetites. Encouragement was given where people needed it to finish their meals. All the meals we observed were unrushed. People were given assistance to manage their meals where necessary.

Snacks were available to people throughout the day. We saw biscuits, crisps and fruit were offered. Drinks

were provided regularly.

We noticed some people struggled to understand the meal options being offered to them, especially in the part of the home which provided care to people with dementia. We raised this with the manager, to suggest plated meal options could be shown to people to help them make their choice. They said this was supposed to happen already.

We recommend the service follows good practice guidance in providing plated meal options for people with dementia, to help them make a choice of what they would like to eat.

Good

Is the service caring?

Our findings

We received positive feedback from people. Relatives said "I'm very happy with the service so far, the carers are nice, always chatting to her," "They have been very caring and don't take any notice of his swearing" and "If I wasn't happy he wouldn't be here. The carers are caring and nice." Another visitor told us "I'm very happy with standards of care; they work very hard." One person said "They (staff), do try hard," another person gave us a 'thumbs up' sign when we asked what staff were like.

People told us staff were respectful towards them and treated them with dignity. We saw staff knocked on people's doors and waited for a response before they went in. Doors were closed whilst personal care was being given, to protect people's privacy. People cared for in bed were kept comfortable and warm.

We saw people were treated with dignity and compassion towards the end of life. Anticipatory medicines had been obtained to ensure people would be kept comfortable and that any pain was controlled as they reached end of life. Anticipatory medicines are medicines, such as pain relief, kept at the home for the person. The benefit of having a supply of anticipatory medicines is that they are available when needed. For example, it could be difficult to get these medicines in a hurry, especially at night or at weekends so it is helpful to have them ready.

Staff were knowledgeable about the people they regularly supported. For example, they told us about people who had been in the army, any hobbies or interests people had and about their families. Staff told us about one person who liked to garden. We saw they had been supported to take gardening books out of the library and they had made use of a greenhouse and vegetable patch in the garden, which they were proud of.

People's birthdays were celebrated at the home. The birthday of one of the residents was discussed in the seniors' meeting we attended. Arrangements were made to make a cake and hang a birthday banner in the lounge for the person.

People's bedrooms were personalised with items such as ornaments, pictures and photographs. People appeared happy and we saw lots of smiles as we went around the home. Staff were courteous and said 'thank you' and 'you're welcome' when they engaged with people. We observed a moving and handling manoeuvre was carried out gently. Staff took their time and said 'thank you very much' to the person they were assisting.

People could spend time on their own if they wished. We saw some people liked to spend time in their room after lunch, a couple of people liked to stay in the dining room.

A member of staff we talked with spoke positively about a friendship which had developed between two people who lived at the home. They were supported to spend time with each other, such as in the dining room and when they relaxed in the afternoon.

Staff showed concern for people's well-being in a caring and meaningful way. For example, we heard a member of staff say to a person "How is your foot? I can see it is very swollen." The person responded and said it was alright and "I'm just exercising it" to help the swelling go down.

We observed someone being helped to walk to the dining room by a member of staff. The person began to cry and said they did not want to go in there. We saw the member of staff was calm and reassuring and led the person away; we later saw the person happily eating a meal in the lounge.

Staff respected people's confidentiality. Care plans and other personal documents were kept secure when not in use in nurses' stations.

People's visitors were free to see them as they wished, to maintain contact.
Information was noted in people's care plans about how they communicated and whether they could make decisions. We heard some of the staff at the home were able to communicate with people in their first language. For example, Polish and Punjabi. Staff involved people in making decisions, such as meal choices, participation in activities and where they wanted to spend their time. Residents' meetings were held at the home. Minutes of the last meeting in December 2016 were available in reception.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to care needs. Comments included "I can tell the nurse anything and they soon sort it out, like the doctor." A visitor said their relative "Has to be re-positioned every two hours and two carers come to do that day and night. It's in the record book which is left in his room, so I look at that regularly." Another relative told us "I feel appropriately involved with the care plan. It's reviewed every year, which I feel is frequent enough."

Care plans took into account people's preferences for how they wished to be supported. People's preferred form of address was noted and referred to by staff. There were sections in care plans about supporting people with areas such as nutrition, personal care, mobility, social interests and personal safety. We found care plans had been reviewed regularly and were up to date.

There was a section in each care plan to record information about the person's life history. This is particularly important in helping to provide person-centred care. In two of the four care plans we read, the life history section did not contain any information about the person.

We recommend the service follows good practice in recording information about people's life histories for all residents.

Staff we spoke with knew about person centred care and how important is was to provide this to people. One member of staff said "It feels like a person-centred home. Residents are treated individually here."

There were reminiscence boxes outside people's bedrooms in the part of the home which provided care to people with dementia. These contained personal items and references that held significance to the person to help them locate their bedroom.

The service supported people to take part in social activities. There were notices and picture boards with information about forthcoming activities displayed in the building. We saw people engaged in gentle exercises, singing and board games. The activity organiser was trained with the National Activity Providers Association. This aimed to provide meaningful activity for older people. We heard that a range of activities and events were arranged for people, including gospel singers, visits from the library including audio books, forthcoming pub lunches and arts and crafts. There had been involvement from the Prince's Trust to work on the garden. A local school invited people to a party which four people attended. There was support from visiting clergy once a month. A hairdresser also supported the home.

A relative said "We were pleased he was taken up to the Valentine's Day event. There was a singer and he had a glass of champagne." Another relative told us "The girls do well with the activities."

There were procedures for making compliments and complaints about the service. Two complaints were recorded in the complaints log book. We saw these had been looked into by the manager and a written response was provided to each complainant. Changes were made where appropriate. For example, in one

case we read relatives were offered a bedroom for the person on a different floor of the building. This was accepted and resulted in the person receiving support more appropriate to their needs. One compliment was recorded. This thanked staff for the care they had given.

Staff took appropriate action when people had accidents. For example, we saw staff noticed someone had a swollen wrist. Arrangements were made for this to be x-rayed and staff accompanied the person to Accident and Emergency at the local hospital. Staff knew there was likely to be a wait at the hospital and made sure they put aside lunch for when the person returned home. Accidents and incidents were recorded appropriately at the home. These showed staff had taken appropriate action in response to accidents, such as falls and unexplained injuries.

Requires Improvement

Is the service well-led?

Our findings

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. We had not been informed about the outcome of DoLS applications or where safeguarding incidents had happened between people who lived at the home. For example, if one person slapped or hit another.

This was a breach of regulation 18 the Care Quality Commission (Registration) Regulations 2009, as the service had not notified us of all important events.

The manager had informed us about some incidents and notifiable occurrences, such as injuries and deaths and from these we were able to see appropriate actions had been taken.

People were potentially at risk from unsafe record keeping at the service. Several of the records we asked to see were difficult for managers to locate and involved considerable searching. These included records of safety checks, servicing and reports from external bodies such as the food standards agency. We needed to ask for a couple of records to be forwarded to us after the inspection, as they has not been located during the three days we were at the service.

We recommend the service follows good practice guidance in the filing and storage of records.

Other records, such as care records and medicines administration records were in better order and were located promptly in the appropriate treatment rooms or nurses' stations.

Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, whistle blowing and safe handling of medicines. These provided staff with up to date guidance.

The home did not have a registered manager at the time of our inspection. An application to register a person had been withdrawn shortly before the visit. We were told about another person who was considering the registered manager role although the arrangement was not confirmed.

We received positive feedback about management of the service. A healthcare professional said "Since (the manager) has been in place there has been an improvement in the general care being given in the care home and a feeling of calm. He has successfully recruited more staff and improved the training of the existing staff." Staff said they could approach the manager; one described them as "very approachable" and said "he listens"; another said the manager was "exceptional" and described how supportive they had been. A third member of staff described them as "very caring." A person who lived at the home said "You can tell him anything you want, he's as good as gold he is." A relative told us "Since the new management, things have got better." We observed staff, visitors and people who used the service were comfortable approaching the manager to ask for advice and to pass on information.

Monitoring took place of people's care. There were management tools to assess standards of care. This included areas such as staff training, numbers of falls and accidents, people who had lost significant amounts of weight and information about pressure wounds. Audits were also carried out. There had been an infection control audit; an action plan was in place after areas of improvement were identified. We read two examples of audits carried out by the provider in 2016. These were comprehensive assessments. We were able to see actions were being taken where shortfalls had been identified. For example, a medicines trolley had been made more secure, confidential records were kept safe and sharps bins were not overfull.

The home had a statement of purpose. This included core values such as privacy, dignity and choice. We found staff upheld these values in our observations of practice at the home.

We found there were good communication systems at the service. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission without delay of the outcome of any request to a supervisory body to deprive a person of their liberty made in accordance with the Mental Capacity Act 2005 or reason for its withdrawal; and the date of the outcome or withdrawal, and any abuse or allegation of abuse in relation to a service user. Regulation 18 (2) c, d, e.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person or in accordance with the Mental Capacity Act 2005 where people lacked capacity. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were placed at risk of harm as effective recruitment procedures were not always used at the home. Regulation 19 (1), (2), (3), (4).