Ridgewood Care Services Limited

The New Inn

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Inspection took place on 29th June 2016 and was unannounced.

The New Inn is a care home registered to provide accommodation and personal care for a maximum of ten people with learning disabilities. At the time of our visit there were 9 people living in the home. At the time of our inspection there was a registered manager at the home. 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.

Audits did not always identify actions to improve the service. During the inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's safety had been assessed and actions taken to protect people from the risk of harm. The provider also had systems in place to reduce the risk of people experiencing abuse. When concerns were raised, the provider had investigated these thoroughly and action had been taken to protect people when necessary.

Medicines were managed safely and people had access to their medicines when they needed them. However, as required medicines were not clearly audited when counting stock from one month to the next. We recommend that the registered manager reviews the procedure for stock checking all medicines

Staff were well trained and there were enough staff with the right skills and knowledge to provide people with the care and assistance they needed. They knew the people they cared for well and treated them with kindness, compassion, dignity and respect. Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly. New staff were inducted in the service when they started working there but the process was not consistent. We recommend that the registered provider implements a consistent induction programme for all new staff.

The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout the day of our inspection, such as staff sitting and talking with people as equals. People could have visitors from family and friends whenever they wanted.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. People led full and varied lives and were active in their community.

Support plans ensured people received the support they needed in the way they wanted. Peoples health needs were well managed by staff so that they received the treatment and medicines they needed to ensure they gave consent. Staff respond effectively to people's needs and people were treated with respect. Staff

interacted with people very positively and people responded well to staff.

Complaints were responded to appropriately however not all complaints were recorded. We recommend that the registered manager reviews the complaints recording process.

The culture of the service was open and person focused. The registered manager provided clear leadership to the staff team and was an active presence in the home. The manager provided active cover on the rota however this sometimes meant that they did not have sufficient time to fulfil their management role. We recommend that the registered provider reviews the management hours available.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood how to protect people from abuse and avoidable harm.
Staffing numbers were sufficient to keep people safe.
Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were trained to deliver effective care that met people's individual needs.
People received adequate food and drink.
People were supported to access medical professionals to ensure their good health.
Care was only provided with people's consent and the principles of the mental capacity act were followed.

Is the service caring?

Good

The service was caring.

Staff knew people really well, had developed positive relationships with them and treated them with respect and compassion.
People were involved in all areas of their life and were supported to be independent.
Staff promoted people's right to privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff were responsive to their needs.
People and their relatives were involved in planning and reviewing their care.
Complaints were dealt with promptly however they were not always recorded as complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality monitoring systems did not consistently identify areas for improvement to ensure positive changes were made
The culture of the service was open and person focused.
The registered manager provided staff with clear leadership and support.

The New Inn

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 29th June 2016 and was unannounced.

The inspection team consisted of two inspectors and an inspection manager.
Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As some people who lived at The New Inn were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, five staff, five people who lived at the service and three relatives. We looked at a range of records about people's care and how the home was managed. We looked at three people's care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected The New Inn in February 2014 when we found they were meeting the requirements of the regulations.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt the home was safe. One person told us, "The staff look after me here. I like them, I do." One persons' relative said, "Yes X is safe. It [the home] is close to the road but they're usually with someone and wouldn't wander off on their own".

Staff understood how to report safeguarding concerns. Staff felt confident in how to report concerns and were able to describe the correct process. One member of staff said, "We have a duty to report it [concerns]. We wouldn't be doing our job if we didn't." The registered manager had identified some risks to people following a recent incident and had taken action to keep people and staff safe. Staff had access to the latest safeguarding policy issued by the local authority. This meant that they were aware of the correct reporting procedures and had access to the latest guidance.

The service had identified possible risks to people and assessed how to keep people safe. There were detailed risk assessments and these effectively managed any potential harm to people. There was an extensive list of risk assessments to reduce potential harm when people were being supported in and out of their home and with different tasks. In each risk assessment the focus was on promoting people's safety when they were being supported to allow people to achieve as much independence as possible whilst remaining safe. This meant that people were able to safely access the local community and pubs on their own and be independent and valued members of their local community.

The registered manager had considered other hazards to people, for example the risk of being bullied or from aerosol abuse. Some people were being supported to minimise dangers to themselves through the use of positive behaviour support plans. Positive behaviour support plans are used to help people manage any behaviour that challenge. They contain strategies to reduce anxiety and to keep staff members and people safe. One person could display a wide range of emotions and each emotion was described in terms of what it meant to the person and how staff could help the person to manage their feelings, such as sequencing the events of the day in clear language or helping them to a quiet place. This meant that staff had effective ways to keep people safe when they were feeling anxious.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. The registered manager had ensured incidents were responded to. Records showed that one person was very upset for periods over three hours. The staff had followed the positive behaviour support plan guidelines. This meant that staff and people were kept safe and the situation was de-escalated by using the strategies in their positive behaviour support plan, such as disengaging when the person was angry. The staff team had reviewed strategies after the incident showing that they were safely and effectively managing incidents and reducing the risk of harm to people. The accidents book showed 3 accidents in the last year: all had been recorded and were managed well.

Staff told us they felt there were enough staff on duty to meet people's needs. They said that staffing levels were adjusted if people's mental health changed. Staff said that they would often be allocated to support a person on a 1-1 basis if they became unwell and needed additional support. Staff said, "Generally there are

enough staff and staff numbers go up if needed. We are all here to support each other." People's care needs had been assessed and a staffing level to meet those needs had been set by the registered manager. Levels of staff seen during the day of our inspection matched with the level identified by the registered manager as being required to meet people's needs. Staffing rotas also confirmed that the appropriate number of staff were in place to support people for the previous month. People were supported by staff to attend activities and appointments. While this took place there were enough staff left at the home to care for the people who stayed in.

The service followed safe recruitment practices. Records showed that staff files included application forms, records of interview and appropriate references. The registered manager had ensured that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. The registered manager had sought references from previous employers. In cases when references were not returned the registered manager had made contact with the referee to ensure people were safe and suitable to work.

There were safe medication administration systems in place and people received their medicines when required. All medicines were blister packed and were stored in a locked cabinet. There were separate areas for people's non-blister packed medicines so each person had one area in the cabinet to store their medicines. This meant that it was clear which medicines belonged to which person.

Medicines were stored safely. The blister packs were colour coded for different times of the day. Homely remedies were kept in a separate locked box. As required medicines (PRN) are medicines prescribed for use at occasional times as directed by a Doctor. PRN medicines were kept in another separate locked box. The keys for the PRN and homely remedy medicines were kept separately and were clearly labelled. Temperatures were recorded and checked daily, which meant that medicines were being stored at a safe temperature. Staff observed the correct procedures for administering medicines and locked the door to the medicines cabinet between giving doses to people.

We checked four people's medicine administration charts and found that all medicines were signed for. One person's chart had been signed twice for a PRN medicine, meaning they had received two doses. However, it was unclear how many tablets they should expect to have in stock. The medicines file in the office showed that medicines were checked and signed in to the home by two staff. The medicines file showed that PRN medicines were being ordered but not always recorded. We checked the actual stock of medicines and found that stock checks were happening but were not clearly recorded, with no running totals from one month to the next. This meant that supplies of some medicines could potentially run low.

We recommend that the registered manager reviews the procedure for stock checking all medicines.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One relative told us, "X would play up and reject people if the staff didn't know how to care for them but they're always happy to go back [to the service] and that's a great comfort to me. That shows me the staff know how to look after X."
Another relative told us, "The staff know how to care for X and this shows in how well they are doing."

Staff had the training and skills they needed to meet people's needs. Records showed that the registered provider had in place an induction programme for new staff to complete after being recruited. Two staff files did not contain any induction paperwork. The registered manager produced a form from a different file for a new starter, relating to a new induction process that had been introduced in May. This induction form was dated as starting four months after the person had started work. The form referenced an induction checklist, induction planner and induction contract and review record, and set out in a learning agreement that the person would have a 12 week induction programme. However, other details such as the date were missing. The areas to be covered in the induction included practicalities such as use of equipment, but had no reference to care practice or competencies. The regional manager reported that they were developing an induction pack to help new staff learn how to work in the home, and they were working to implement this.

We recommend that the registered provider implements a consistent induction programme for all new staff.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Records showed that supervisions covered staff development, and how the staff were feeling in their role. Staff were able to discuss any personal problems with their manager and were listened to. The registered manager ensured that staff were able to discuss the people they support in a confidential setting. Annual appraisals were held with staff to monitor their performance. This meant that people were being looked after by a staff team who were supported by their manager.

People were supported by staff who had the opportunity to maintain their skills and knowledge. There was a full training programme in place to ensure staff had the skills and competency to support people. Records showed that staff were trained in areas such as food safety and fire safety and had received a comprehensive training programme that reflected the needs of people they were supporting. In addition to the courses that were offered to care workers as standard practice, the registered manager had ensured extra training was available. Staff said they had recently completed a three day challenging behaviour course with the local authority community team. One staff member said, "It was a great session as we looked at real life scenarios." Staff said they also reviewed people's personal behaviour support plans with the team as part of the training. This meant that staff were being supported to keep people safe and to reduce the impact of behaviours that challenged.

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's files contained MCA assessments for specific decisions such as managing their money. The assessments took account of people's right to make unwise decisions and checked they understood the consequences of doing so. They also took into account the person's views before a care plan was written. For example, one person had been assessed as having the capacity to make decisions about their money and to manage their money. However, they had expressed anxiety around this and had requested staff support. A plan was put in place to explain the support that had been agreed with the person.
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 in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had ensured that people's freedom had not been restricted and systems were in place to keep people safe.

Staff sought people's consent before helping them. On the day of the inspection visit one person was supported to clean their bedroom. However, this was only done when the person agreed to clean their room after several attempts were made to explain why it was a good idea. Throughout our visit it was evident that it was part of the culture of the home for staff to always seek consent from people before going in to their room, or supporting them with a task.

People had enough to eat and drink to keep them healthy and were happy with the quality, quantity and choice of food and drinks available to them. People were able to choose when to eat and were involved in preparing meals. People told us they liked the food and were able to make choices about what they had to eat. One person told us, "I write the menus when it is my turn; I like to have shepherd's pie." The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans.

People were supported to stay healthy. Records showed that people had health action plans. Some people were attending a weekly exercise session. Others had a weekly reflexology session. One person said, "I like having my feet massaged, I enjoy it." Care files demonstrated that people had regular access to external health care professionals. People also went out to regular appointments to their GP opticians, chiropodists, dentists and other health professionals when needed as well as attending routine reviews. There was input from the local Community learning disability team for most people. Where people's health had changed appropriate referrals were made to specialists to help them get better. One person's file showed that the registered manager had made referrals and staff members had taken effective action, to address a change in the person's health.

Good

Is the service caring?

Our findings

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. Staff clearly knew people well. They were able to tell us about what people enjoyed doing and what support they needed. People who lived at the service also seemed to get on well with each other. They were chatting together during the day and helping each other with tasks like laying the table. People had keyworkers. A keyworker is a member of staff who takes the lead in one person's care and support. A person was chatting with their keyworker and planning a day out. The staff member said, "We get on really well as we have a lot in common. We enjoy going out together." Staff told us they were matched with people based on shared interests or particular skills.

Staff were caring towards people. People were treated with kindness and compassion. One person told us, "I like living here. You get looked after". One person was unwell with a heavy cold and staff were making honey and lemon drinks and encouraging the person to drink them. Another person mentioned they had a sore throat too and they were immediately made a drink and given kind verbal comfort. There was a lot of positive interaction and laughter between people and staff. Staff and people interacted as equals, having drinks together and playing games such as heads and tails, or word games, which people were clearly enjoying.

The home was a happy place and there appeared to be mutual affection between people who lived there and the staff. One person told us, "I like living here. My mum is too old to look after me. The staff are caring, they look after me." A relative told us, "The staff always seem to be happy. X would reject people she didn't like but she's always happy and that's a good sign." A care plan contained the comment, "X is a valued member of the house." During our visit it was observed that people responded well to their staff team and were keen to engage in conversations and fun interactions. There were puppies in the home on our visit and people engaged with staff in talking about the puppies and laughing when they tried to leave their enclosure.

Care plans ensured that people were able to make choices. One of the outcomes in the care plans was: "For staff to support X in the decisions she makes without imposing their own views upon her", and "For staff to discuss the options and consequences if X has made a decision that is felt to be a health and safety risk". This showed that people were being supported to make decisions by a staff team that valued people's decisions.

People's independence was encouraged through support planning and people were supported to make choices. One care plan explained, 'X has stated that they would like staff to support them with money and to look after their wallet'. The care plan showed that staff had supported the person to develop their money skills. The person had consented to having an appointee and this was recorded correctly. An appointee person who has been appointed by the Department of Work & Pensions or a local authority to receive welfare benefits on behalf of someone who is unable to manage their financial affairs. Staff knew people's individual communication skills, abilities and preferences. One person had been given advice by a speech

and language therapist to use a speech aid with pictures. However, the person had refused to use this device as they did not like it and all staff respected this choice. People had been supported to vote in the EU referendum if they wished. Some people had chosen not to and others had voted in person or by a postal vote. The staff had helped them to access easy read information to help inform their decision.

Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. One care plan showed that a person accessed a psychologist for low self-esteem and required staff support around this need. This need was met by giving the person more time to express themselves. The care plan explained how the person will take themselves away to their room and then will speak to staff afterwards when they are ready.

People we spoke with said that they were treated with dignity and respect. One person said, "The staff are always kind to me." Throughout the day we observed staff encouraging and offering people choices and respecting their decisions. For example, one person was asked by a member of staff if they would like to move to another area or if they preferred the room they were in. People were also asked where they would like to eat and if they were ready for their meal. Staff used kind words and gentle encouragement to reassure people who were a little apprehensive. When a person's dignity was compromised staff were discreet when dealing with the situation and helped the person to their room for assistance. Staff were discreet when discussing people's needs. Information about people was stored securely to ensure it remained confidential.

Good

Is the service responsive?

Our findings

People received a service that was responsive to their needs. People and their relatives were involved in developing their care and support plans. One relative told us, "I always go to reviews and parties. They usually pick me up and bring me back." Care plans were personalised and detailed daily routines specific to each person. It was evident from observations and speaking with people and staff that the service was focussed on people having choice and control of their lives. Staff asked people what they wanted to do, if they wished to go out somewhere, what they wanted to eat and drink. One staff member said, "If people want to do things it is never a No. We always look at what we can do to make it happen for them. People have lots of choice here." Another staff member said, "This is the best home I have worked in because people have so much choice."
Two people had voluntary work experience roles at a local hotel. There was not a clear plan in place that stated if this was leading to the achievement of any particular goal but people told us they enjoyed going to work and having a job.

Staff told us that some people were able to go out without staff support, for example one person went to the local shops and others went into town or to the library. One person told us, "We go to a dance workshop at the college and have a music session each week. We go bowling, shopping and out for lunch. We do lots of things really." Another person told us, "I like going to the pub, it's my local." One relative told us, "They keep people occupied: X is always out for a drink, to the harbour, shopping, to shows and she has a nice little social life. When they collect X she's always happy." One person went weekly to church. Staff said one person had not been confident about going out alone, but had wanted to walk the dog that belonged to the house. They had begun to do so and staff support had decreased gradually. This has resulted in the person going to the local shops and nearby pub alone or with peers. Staff and people told us about a course they were doing at the library called 'Beyond words' which was using pictures to create stories. People's diaries showed that they went out somewhere most days to do things that their care plan stated they enjoyed.

Staff told us they were allocated as a keyworker to a person. They told us "As keyworker it is my responsibility to do a monthly review of their health needs and goals and feed this back to the manager." The record of keyworker meetings showed these happened regularly and reflected the person's views about the service, staff and how they were getting along with others in the home. One person had raised that they wished to go swimming. Staff and the person confirmed they had done this. People were reminded in the keyworker meetings that they could talk to their keyworker at any time or talk to any other staff if they had any concerns or needed anything. One person had a goal to go for a ride in a helicopter. The registered manager told us this had been achieved, "We made sure that happened and they went on a helicopter at Goodwood."

Staff said people were able to get out when they wanted to because the house had two vehicles and the home was located within walking distance of the local town and rail station. Staff responded when people asked for support and also offered support if they needed it. For example, a person had shaved that morning but had missed part of their stubble. Staff acknowledged that the person had done well, but discreetly offered to help them finish their shave to make sure they hadn't missed any bits.

People had detailed care plans that reflected their assessed needs and their wishes. For example one person had a social care plan that included support to go to the local pub twice a week. It noted they enjoy chatting with locals and playing music on the juke box. Records showed that people were being supported to engage with activities that they have chosen to do and were recorded in their support plans. People were able to make changes to their planned activities. For example one person had planned to go bowling but had chosen on the day to go shopping and out for lunch. This meant that people had control of what they did each day and their decisions were respected by staff.

People were supported to write their own daily diary notes. Staff checked the report and signed it, adding any comments if needed. Staff said it was a useful way of encouraging people to take control and responsibility for their lives, but also enabled the staff to pick up on any changes in mood or emotional well-being. We checked with staff what would happen if sensitive information needed to be exchanged and were told that any sensitive information would be shared in the communications book, for example if a person was refusing to bathe. This allowed people to write their own daily notes and be in control of the support they received.

Care plans were responsive to people's changing needs. One person's plan acknowledged they had different support needs depending on their mental well-being. The plan outlined the support required in both possible situations and records showed that their support was adapted as per the plan. People and their relatives were involved in the planning of their care. Regular reviews were held with relatives and the local community learning disability team.

The registered provider sought people's opinions of their service through annual surveys and three relatives completed a satisfaction survey in May 2016. Two people raised an issue and the registered manager took action to correct the situation. There was a complaints policy in place. The policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission. A relative confirmed they knew how to make a complaint, but had never felt the need to. The complaints file contained one document dated 2016, which was a statement from a member of staff at the home outlining their concerns with the service at a primary medical practice. There were no records of any complaints, concerns or compliments about the service. The registered manager said that there had been no complaints, that any compliments tended to be verbal and they had not recorded these.

We recommend that the registered manager reviews the complaints recording process.

Requires Improvement

Is the service well-led?

Our findings

People knew the registered manager very well. As soon as they entered the building people approached them and engaged with her by making jokes. A staff member said, "The manager is approachable. I can discuss anything with her and she is very supportive." A relative told us, "I know who the manager is and get on with the staff and all the people who come over."

Quality assurance systems were in place to monitor the quality of service being delivered however they did not consistently identify shortfalls and result in action. Some areas of the home were not clean. In the laundry room the floor, skirting board and behind the door were very dirty and the floor was sticky. The care plan for one person stated they had anxiety about dirt and the plan was to ensure their living environment was clean. There were no clinical waste bins in the upstairs bathroom and sanitary products were in the general waste bin. This was a potential infection control risk. The light pulls in bathrooms were very black and dirty. There was cracked plaster on the walls in a recently decorated corridor and the painting had been completed with a different shade of paint meaning that the environment did not look homely. The bath panel was broken on the ground floor bath making it hard to clean and a potential infection control risk.

There was no cleaning schedule in place for the laundry room. There were also lots of gaps in other cleaning records. For example in the week commencing 6th June 2016 the records of cleaning for communal areas and bedrooms were not completed on the Monday or Friday. In another week in June there was no record for the Tuesday, Wednesday or Sunday. Quality audits had identified some of these issues but an action plan had not been generated and improvements had not been made by the day of our inspection. This meant that the home was not clean to the standards that people should expect.

The lack of effective auditing systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a positive culture that was person-centred, open, inclusive and empowering. The registered provider had a well-developed understanding of equality, diversity and human rights and put these into practice. The registered manager told us, "It's a family environment and we're visitors in their home. It's very relaxed but there are guidelines and boundaries. We let people do what they want." "We pride ourselves on being open. If something goes wrong we contact social services and we are always transparent." The registered manager spoke about the culture of the home and told us, "I'm so proud of the staff team. It's not just a job and they really care about people and want to give them the life they deserve." During our visit we observed the culture of the home to be one where people were supported to do what they chose, within a caring environment.

The registered manager was a very visible presence in the home and people clearly knew who she was. The registered manager told us, "I observe people and work shifts so I can see staff in action and also catch up with them." The registered manager provided a positive role model for the staff team. Records showed that the registered manager would often work shifts to provide direct care, especially when covering staff sickness. The registered manager acknowledged that recruitment was a challenge. However, they also felt

that as a result of working shifts they did not have enough management time. Records showed that the manager did not often have supernumerary time on the rota and told us, "I think in the last few weeks I haven't had a management day and have been on the rota." This meant that some office based work was not being completed.

We recommend that the registered provider reviews the management hours available.

Staff were able to access support from the manager in supervisions and appraisals. Staff said they felt supported by the manager and could approach the management team to raise concerns.
The registered manager ensured that staff meetings were held. Records show that these were happening monthly. Records were on file of meetings with the local authority learning disability team.

There were systems in place to provide management to the service in the event that the registered manager was absent. In the event that the manager would be unavailable for a short space of time the deputy manager would take over. The service was supported by regular visits from a senior manager. The senior manager was new in post and was setting up quality assurance and management systems to provide a clearer framework for management of the home. Records showed that audit systems were being prioritised and we saw a training audit that had effectively identified gaps in training and implemented a timely response. The registered provider had effective systems in place for contingency planning.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know how to respond if they had concerns they could not raise directly with the registered manager.

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 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured audits effectively identify actions to improve the service