Care Quality Commission

Care Uk Community Partnerships Ltd

Elmstead House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 16 June 2015 and was unannounced. Elmstead Nursing Home is a nursing home that is registered to provide accommodation nursing and personal care for up to 50 people. The service specialises in: dementia, diagnostic and/or screening services, learning disabilities, mental health conditions, physical disabilities, and caring for adults over 65 years old.

The home was split into two units, one for people who had memory problems and were physically frail and the other for people with mental health difficulties. At the time of the inspection there were 46 people living in the home with 28 people on the dementia unit and 18 on the mental health unit.

The home had a registered manager. 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.

Whilst most aspects of the home were safe, people were not fully protected against the risks associated with medicines. There were also some gaps in records for people who were unable to consent to care, and required best interest decisions to be made on their behalf, so it

Summary of findings

was not always clear if all relevant parties had been consulted. Some people expressed concerns over staffing numbers at weekends, during meal times and medicines rounds.

Staff showed a good knowledge of people's life histories and preferences regarding their care and support needs. They knew what to do if people could not make decisions about their care needs, and the procedures for reporting abuse. Safe systems were in place for recruiting staff, and the home was kept clean and hygienic.

People were provided with a choice of food, and were supported to eat when this was needed, some improvements had been made to food provision following a recent food satisfaction survey. People had a range of activities available to them, organised by two activities workers.

People's health needs were met, and they were supported to consult with health and social care professionals as needed without delay.

People had the opportunity to be involved in decisions about their care and how they spent their time at the home. They and their relatives attended meetings during which they could raise any issues of concern.

The provider had systems for monitoring the quality of the service and engaged with people and their relatives to address any concerns. When people made complaints they were addressed appropriately.

Staff received regular supervision and training relevant to their role. They felt well supported by the management, and able to speak up about issues of concern to them.

At this inspection there were two breaches of regulation in relation to medicines management, and compliance with the Mental Capacity Act 2005, and a recommendation is made regarding staffing deployment in the home. You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was not always safe. Some practices for administering medicines were not safe.

There were assessments in place to minimise identified risks to people, and staff knew the correct procedures to follow if they suspected that abuse had occurred.

Safe recruitment procedures were in place, but it was not clear if there were always sufficient staff available in the home.

The home was largely clean and hygienic.

Requires improvement

Is the service effective?

The service was not always effective. Staff understood people's right to make choices about their care and the requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards. However records were not always sufficiently robust to show clear consultation about best interest decisions made of people's behalf.

A training programme was in place, and staff received regular supervision sessions. They told us that they were supported to care for people effectively.

People received a choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Requires improvement

Is the service caring?

The service was caring. Staff were caring and knowledgeable about the people they supported, and understood their preferences and life histories.

There were opportunities for consultation with people and their representatives about their care and support.

Good

Is the service responsive?

The service was responsive. People using the service and their relatives were encouraged to give feedback on the service and use the complaints system.

Care plans were in place outlining people's care and support needs and staff were knowledgeable about people's needs, interests and preferences in order to provide a personalised service. A range of activities were available for people including occasional trips out of the home.

Good

Summary of findings

Is the service well-led?

The service was well-led. The home had systems for assessing and monitoring the quality of the service. People found the management to be approachable and supportive.

Good

Elmstead House

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.

At the previous inspection of the home in December 2013 we found that the home was meeting the regulations inspected. Prior to the current inspection we reviewed the information we had about the service. This included information sent to us by the provider such as notifications and safeguarding information.

This inspection took place on 16 June 2015 and was unannounced. The inspection was carried out by two inspectors, a pharmacist advisor, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we looked at the care plans, risk assessments, and daily records relating to fifteen of the 46 people who were living at Elmstead Nursing Home. We also spoke with ten people using the service, two relatives of people using the service, the registered manager, the deputy manager,the clinical lead and two other nurses, nine care staff, and an activities coordinator. We looked at twelve staff personnel files, the last month and future month of staff duty rosters, accident and incident records, selected policies and procedures and approximately 25 medicines administration record sheets.

Following the inspection we spoke with two staff members, six friends/relatives of people living at the home, and two health and social care professionals, who visited the home regularly.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe living at the home, with the staff supporting them and the management. One person told us, "All the staff here are very good, it's very safe here." We observed staff supporting people to remain safe in the home, reacting quickly to support a person at risk of falling to reach their walking frame, and encouraging people enjoying the garden to sit in the shade during periods of strong sunshine. However although people did not report any concerns around receiving their medicines we found some unsafe practices in the management of medicines administration within the home.

The care plans for some people did not include all the necessary information to enable staff to support them safely with medicines. This included one person who was on high risk medicines and some people who were being given their medicines covertly (disguised in their food in consultation with their GP and representatives). Due to the method of administration of these medicines in food or drink, this task was delegated to care workers. There was no formal delegation or training process and nurses we spoke with, who retained accountability for this process, were not aware of their responsibility under the Nursing and Midwifery Council standards for delegation.

On the day of the inspection we found that 18 out of 28 people on the dementia unit and three of 18 people on the mental health unit had their medicines administered covertly. There was no record of which medicines were offered and administered traditionally first and then after refusal administered covertly. We observed a nurse delegating the administration of medicines to care workers who took the medicines to people who were often out of sight of the nurse. Although they returned to the nurse and confirmed the people had taken the medicines, the nurse who signed the medicines administration records (MAR) did not directly observe these people taking their medicines. We saw records of nursing staff supervision and competency assessments in medicines administration, but although care workers had some training in medicines administration their practice had not been assessed. Nurses were not clear about the difference between covert medicines (without the knowledge of the person taking the medicines) and off label or outside licence administration such as crushing the medicines because a person had swallowing difficulties. For one person there was a detailed plan for how the medicines should be disguised in food, including checks every 15 to 30 minutes to see if the person had eaten/drunk the medicines, however there was no record of these observations being undertaken.

From MAR charts it was not clear which medicines had been given traditionally and which had been given covertly. One person had their medicines administered covertly but their electronic care plan recorded that they had "complied" with their medicines on 3 March 2015. The provider's Agreement for the Administration of Covert Medication stated that, "a dedicated care plan needs to be inserted with the MAR chart which will give information on how the medicine will be disguised." These were not present in the MAR chart folder. We also found that there was no risk assessment in place for a person prescribed rivaroxaban, a high risk medicine.

On checking some people's records we saw four instances where medicines had been out of stock or errors made in the record. We saw records of monthly audits on both units. However on the dementia unit we found some issues that had not been identified in the most recent audit. These included missed single doses of medicines due to a lack of stock. However in one case the electronic care plan still recorded "medication given no issues." These were not recorded on an incident form, nor was the GP informed, and these were not documented on the audit. We could therefore not be sure that audits on the dementia unit were sufficiently rigorous to ensure that incidents were detected and appropriate action and learning was put into place.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All medicines were stored safely including controlled drugs and those requiring refrigeration.

Medicines requiring opening dates to be added to ensure they were not used beyond were found to have had the date added. Medicines were disposed of safely and records maintained.

Medicines were administered as prescribed and we saw that they were recorded appropriately. Where people were prescribed medicines for more complex conditions, we saw that tests were done as needed and clear records kept. People requiring thickening agents had the use of these agents recorded on their MAR charts and with clear

Is the service safe?

instructions on the individual quantities people required. Medicines errors reported in January 2015 had been assessed and reviewed and action plans were implemented to prevent reoccurrence.

Most people living at the home and their relatives told us that there were enough staff available to meet people's needs. When we asked people if there were enough staff, relatives told us, "It seems to be OK, its hard work for the staff. I have to compliment them on what they do," and, "I think so, yes." However two people told us that they were not happy that their relatives were getting the one to one support they needed at night. One of them told us, "[My relative] should have a one to one at night but it's not there. [S/he] tends to wander at night." The other relative said their family member was left in their room for long periods of time, noting, "They are always really short of staff, [my relative] is funded for a one to one but is always alone." They told us that this impacted on their relatives care, so that they had sometimes found them in an uncomfortable position or with poor continence care. They told us, "Carers are always running around trying to do everything. The staff say that s/he is safe, but it's quality time as well as making sure s/he is OK."

We observed call bells being answered quickly during our visit. At the time of the inspection there were 46 people living in the home. On the dementia unit 27 of the 28 people needed assistance with meals. The staffing in the home on the day of the inspection matched the rota, which indicated that there was usually at least one nurse per unit, with another nurse on duty on some days, and with four care workers on each unit. However the rota indicated that there were frequently only three care staff on duty on each unit, with no extra staff on duty to provide one to one care.

Management told us that there were recruiting to fill nursing and care worker vacancies. Staff said that they sometimes found themselves short at weekends, and had difficulties providing one to one support. A nurse explained that delegation of medicines administration was necessary as there were not enough nurses always to cover the morning shift and all the tasks that went with it.

Safe recruitment procedures were in place to ensure staff were suitable to work with people. Staff had undergone the required checks before starting to work at the service. The new staff files we looked at contained criminal record checks, two references and confirmation of the staff member's identity. They also included interview records and checks on professional qualifications.

People who used the service and their relatives told us that they could raise concerns with staff or the registered manager. Staff we spoke with understood the service's policy regarding how they should respond to safeguarding concerns. They knew who they should report to if they had concerns that somebody was being abused. One staff member told us, "If there was an issue with a service user, a bruise or anything that comes under safeguarding, I would report it to my line manager straight away." They had received training in safeguarding adults and we saw evidence that incidents had been reported appropriately.

Risk assessments were in place to ensure that risks to people were addressed and staff signed to confirm that they had read them. There was some variation in the detail recorded in risk assessments for identified risks including choking, falls, and behaviour that challenged the home. For example one person's risk assessment indicated that they were at risk of choking but did not say why or how to decrease this risk. These appeared to be reviewed regularly however there were not always dates recorded to indicate how frequently they were reviewed. Staff we spoke with had knowledge of general first aid and emergency provisions within the home such as resuscitation equipment.

People told us that the service was clean. One relative said, "Everything looks very clean, I see people cleaning." Overall the home looked bright and clean. Cleaning charts were kept which showed that there were clear systems in place to ensure that all areas were cleaned regularly, and infection control audits were carried out regularly. The decorators were finishing off the homes' redecoration project which had seen all the main corridors repainted. Corridors were clean and bright, and the cleaning staff we saw were very thorough. Corridors were kept clear with wheelchairs stacked in an allocated bay. However one downstairs bathroom on the mental health unit smelled very strongly of urine. The deputy manager told us that the flooring in this room had recently been changed, however the odour appeared to be from under the floor or possibly a leaking pipe. He said that he would put it on the maintenance list to be looked at.

Requires improvement

Is the service safe?

We recommend that the service reviews staffing deployment within the home to ensure that there is consistent support for people with complex needs.

Requires improvement

Is the service effective?

Our findings

People spoke positively about the staff that support them. They told us, "I've only been here for a month or so, but it all seems OK to me, nice breakfast this morning," and "I've been here for over 16 years and I can tell you that the staff are really good and work as a team," and "It's really nice living here, we enjoy the food, and there are some alternatives if you want."

People said they were able to make choices about their care. We found that assessments were in place under the Mental Capacity Act 2005 (MCA) regarding people's capacity to make decisions and consent to their care and treatment. However these were not always specific to the decisions being made such as a person's capacity to make decisions relating to their care finance. We saw that some people had been assessed as not having the capacity to make the decision to refuse to take their medicines and a best interests decision had been made to give them their medicines covertly (disguised in food). However some records lacked all the necessary information. For example it was not always clear whether the appropriate people had been involved in the decision. Also it was not recorded whether people would be offered their medicines normally and only given them covertly if they refused. The provider had MCA best interest decisions (BID) records in place for people receiving their medicines covertly and had taken advice from the supplying pharmacist. However the BID records for some people did not contain sufficient detail about how the medicines would be administered and when the decision should be reviewed, and for two people there was no evidence of consultation with relevant people including the doctor, and next of kin. For one person receiving covert medicines there was no mention of this in their care plan.

Staff had received training on the MCA and were aware of the need to ensure that those with capacity were supported to make their own decisions and choices. This was achieved by the staff asking permission to carry out each task to gain their consent. Deprivation of Liberty Safeguards (DoLS) were in place for a large number of people living at the home (who were unable to go out unsupervised, and did not have capacity to consent to this arrangement). Each person's care plan had a section to indicate whether they were subject to DoLS including review dates, and evidence of appropriate assessments such as those by an Independent Mental Capacity Advocate. We also saw evidence of consultation with an independent advocate regarding BID for people who did not have family members to support them.

We found records of face to face induction training for new staff who had commenced work at the home and regular supervision and appraisal sessions for the staff team. Staff told us that they felt well supported by the home's management. One staff member told us, "I really feel supported by my unit manager, who is very helpful and encouraging to me .. I have been doing my e-learning and we have training every month." Another staff member said, "I enjoy working with the residents, and my unit manager is very helpful and approachable. He really has helped me a lot. I'm learning all the time." Other staff told us that they could, "voice out what I need to," and "We have training all the time."

Records of staff training showed that staff had the opportunity to undertake both e-learning and face to face training, with both forms of training required for some topics such as fire safety, dementia care, and safeguarding. Other training included health and safety, moving and handling, food hygiene, infection control, diabetes, mental capacity act, record keeping and first aid training. A training spreadsheet enabled managers to determine which staff still required particular training or refresher training in particular areas. However this did not include specialist nursing training in particular areas such as PEG management or end of life care, although staff assured us that they had undertaken the relevant training, and certificates were available for these courses.

People spoke positively about the quality of food served in the home. One person told us, "The food is good here, and I am pleased with it." Menus were varied with choices available at each meal. Whilst observing the lunchtime experience we found the dining room to be clean and tidy, and the food looked appetising and well presented including pureed food which had been piped.

However we observed a care worker attempting to feed a person who appeared to be asleep. We reported this to the senior staff, who asked the staff member to wait until the person was more responsive. This appeared to be an isolated incident, however following our visit, one relative

Requires improvement

Is the service effective?

of a person living at the home told us, “They are pushing food down the residents’ throats as they have so many to feed…the care staff are lovely but there is not enough of them.”

We observed staff being very attentive support to people living at the home during meal times. This included staff bending to speak to seated people face to face, and prompting people pleasantly and in a personal way. Drinks and snacks were offered throughout the day. There was a jug and cups available for people to help themselves to water in the mental health unit. However these were not provided in the dementia unit.

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. Staff were aware of the dietary needs of people who had diabetes or who were on particular diets. Menus were displayed on the residents/ relatives notice board, with a comment in large type saying, ‘Ask if you want something different.’

Food and fluid charts were in place for people on a reduced dietary intake, or where concerns about their nutrition were identified, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietician or speech and language therapist if they were having difficulties swallowing. Nutrition and hydration was monitored by monthly weight records, reporting by care assistants, fluid balance charts and food diaries. Appropriate protocols were in place for people who received food enterally (directly by tube).

People said that they had access to health care professionals. They confirmed that the doctor visited the service at least once a week, and they could see a dentist, optician and chiropodist when needed. The service made arrangements for people to either attend outside health care appointments or for specialist support to visit them.

We observed that instructions from health care professionals such as a dietitian or speech and language therapist were followed by staff at the home. Clear records were maintained of the outcome of health care professional visits. Health care audits were in place for people in the home including nutrition reviews, pressure ulcer logs and annual health checks.

Good

Is the service caring?

Our findings

People felt well cared for, and that they were treated with dignity and respect. Relatives of people living at the home told us, “It’s a very good care home, very caring. Staff always chat and make us tea when we visit,” “There’s a nice atmosphere there,” “They are very kind though, yesterday one of the managers gave me a lift as I had parked my car far away,” and “They’re very caring, the staff are really nice, all friendly and they tell us how he’s been. They are always helping him.”

Overall we observed staff to be kind, attentive and friendly when talking with people living at the home. Care workers had a good rapport with people living at the home although they did not have time for long chats with people. One care worker told us that they felt that residents were part of their extended family, noting “I even phone in when I’m on holiday to check that everybody is OK.”

However we saw little interaction between staff and people sitting in one of the dementia lounges on the morning of our visit. We observed one care worker approaching a person in one of the dementia unit lounges and with little conversation spooning some medicine into this person’s mouth, which they clearly did not like, but as the staff member kept spooning the medicine very quickly they had to swallow. Throughout the rest of the day we observed this staff member being very patient and caring with people, including those exhibiting behaviour that challenged staff.

Staff showed patience and skill at supporting people with behaviour that challenged, and calming situations when people became agitated. They appeared to know people’s preferences well, and spoke with them as individuals, supporting people to use the garden area if they wished. We observed a staff member placing a keyboard on the table in front of one person, saying, “I think you used to play the keyboards, do you want to have a go on this keyboard?” The person proceeded to touch the keys. We observed staff preparing people to go on a picnic organised by the activities staff. It took about 20 minutes to get everybody seated into the taxis and there was a lot of laughter and talking as the group went off on their picnic.

Some people were able to be involved in making decisions about their care. Care records included a place for people or their representatives to sign to evidence consultation, and record their opinion, but these had not all been completed.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds. A religious service was held at the home monthly for people wishing to attend. One of the activities coordinators told us that they were trying to develop links with other religious groups, noting “We’ve got some volunteers from the local Catholic church coming in, but I’m still trying to get some further support for other religions.” We were told that some people were supported to go to a place of worship on a weekly basis.

Bedrooms had been personalised according to people’s wishes making them homely and all rooms had en suite facilities. Staff told us they always knocked on people’s doors and waited for an answer before entering, and our observations confirmed this. Throughout the building there were large paintings on the walls along the corridors, and people living at the home spent time looking at them. These included paintings of London buses, red telephone boxes, and country cottages. We saw people looking at the buses, and care workers reminiscing with them. There were also notice boards around the home including relevant information for people living at the home such as menus, and the activities schedule, including sessions in the home’s sensory room.

Good

Is the service responsive?

Our findings

People spoke highly of the care provided to them and responsiveness of staff. One person told us, "I really like living here. I get a cup of tea in my room at 7am, and I can then choose to do what I like." Relatives told us that the home was good at contacting them about any changes in their family members' care needs. One relative told us that they were very happy with the care their family member was receiving and said that they would have complained if there had been a problem. Other comments included, "I think it's really good, they look after him," "The care is good," "He's more settled there that anywhere else he's been. It's a big relief," and "They tell me everything that's going on." However one relative was unhappy with the home's management of their family member's weight loss.

People were given choices about how they spent their time. We observed staff supporting people for walks along the corridor and in the garden, and playing games of their choice. One person who had previously been a boxer was encouraged to do some shadow boxing which they clearly enjoyed. One person who became agitated was asked if they would like to return to their room, and supported to do so when they requested. This episode was handled well using encouraging comments, and without any rushing.

There were two activity staff members. There was a schedule of activities for the home and the morning activity during our visit was a bible story and singing group in the chapel with songsheets handed out. People from both units attended, and this appeared to be a popular session. The lounge in the mental health unit did not contain many materials for activities other than some CD's and the television. However we noticed a game of bingo starting up between two people living on that unit. A picnic was organised at a local park in the afternoon of the inspection. The home had a dog, and we observed some people living at the home enjoying spending time petting it.

Other activities recorded for people living at the home included arts and crafts, massage, relaxation, gentle exercise, bowling, cake baking, foot spa, music therapy, board games, meals out, quizzes, walks, dance, manicure and make up, cinema afternoons, and book readings. Other recent events included a tea party, local school raffle, karaoke session, and a trip to the seaside.

All care plans had an overview summary for each section, including standard and personalised sections. In some files the personal information records were not completed, including the reason for admission, allergies, dietary likes & dislikes, identifying features, and languages. Care needs included activities, behaviour that challenged, eating and drinking issues, end of life requirements, maintaining a safe environment, mobility, personal hygiene, sleeping, and personal care. In some people's end of life care plan it was recorded that they were unable to articulate their preferences, however there was no record of how this would be addressed. Some care plans were signed by people's next of kin to evidence consultation, however the majority were not signed by people or their relatives.

Appropriate records were in place to record and monitor people's care provision. There were communication books between staff members, handover charts, and task checklists. We observed turning charts being completed for people at risk of pressure ulcers, and food/fluid charts in place for people at risk of dehydration or poor nutrition.

People were aware of the home's complaints procedure and told us that they felt able to complain if they were unhappy about anything. They were also able to raise any concerns at a regular residents and relatives meeting held at the home. A relative of a person living in the home told us, "If I have any problems there is a meeting once a month and we can ask anything."

We found that there was a clear record in place of all complaints received since the last inspection, including details of action taken to address them. There was information displayed in the home explaining how to make a complaint, and minutes of recent resident and relatives meetings showed that people had an opportunity to raise their individual and group concerns.

Good

Is the service well-led?

Our findings

People and their relatives were very positive about the home's management. They told us, "Lorraine [the manager] is very nice and helpful," "They always talk to us, any of them will talk to us," and "Everything is perfect here - perfect." One relative thought it would be helpful to have more information for new people moving into the home about meal times and other routines.

Staff felt the manager was supportive and approachable. They told us "We often see Lorraine around the home, she's very nice," "I come to work with a smile – you've got to enjoy your work, and I do here," and "Lorraine is very approachable and she told us in a recent training that if we had any problem with anything, we could talk with her.I feel part of a team here." Staff were aware of the organisation's whistle blowing policy. A staff member told us, "If I saw a problem, I would first speak with my nurse in charge, but I would have no problems in escalating anything I saw as a problem to Lorraine."

Staff meetings were held two to three monthly, with the most recent meetings held in June, April and January 2015. Issues discussed included appointing a staff representative, training, supervision, maintenance and infection control, activities, punctuality and uniforms. Head of department meetings were held monthly with recent meetings looking at training, supervision, activities and accidents. There was also a night staff meeting in February 2015.

The most recent resident/relatives meeting was held in April 2015, with previous meetings held in January 2015 and November 2014. The home's menus were discussed, with an agreement to increase the choices available.

The results of the 2014 Residents Satisfaction Rating Survey were posted on a noticeboard on the corridor wall in the home. It showed that in 2014 people's main issues were with the smell of the home, the location of the building, and food choices. There was a 98% satisfaction rate recorded from this survey. The Relatives Satisfaction Rating Survey for that year, brought up the same issues, with an 84% satisfaction rate recorded. Following the survey more options had been provided on each menu, with at least two choices for each meal in addition to the option of an alternative such as an omelette, salad or jacket potato.

There were records of recent quality outcome reviews held in the home. These included a review of Mental Capacity Act (MCA) training, with 79% of staff having completed the face to face training and 63% having completed e-learning. There were also reviews of health and safety, record keeping, and a review of the home's compliance with the five questions assessed by CQC. The action plan for these reviews included implementing formal daily team briefs, and increased monitoring for people who lost weight.

There were regular audits of kitchen standards, infection control, health and safety, nutritional needs, night care, and medicines. A recent meal time experience audit highlighted some safety issues, and showed that people were not always told what was put on the plate in front of them, and sometimes had to wait too long for meals. An action plan was put in place to address these issues.

A representative from the provider organisation visited the home in January and February 2015 to check on the home's performance. The most regional governance audit was completed in October 2014 looking at risk assessment completion, accident and incident analysis, and staff understanding of the MCA.

We saw records of current gas safety and electrical installation certificates, portable appliances testing, water testing, lift and hoist servicing, fire equipment servicing and regular fire drills and call point testing. There were also regular checks on window restrictors and bed rails. Incident and accident records were recorded with details about any action taken and learning for the service. Incidents and accidents were reviewed by the registered manager and action was taken to make sure that any risks identified were addressed.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not ensure that sufficiently detailed records were maintained to ensure that people's care and treatment was provided with their consent or a best interest decision made in consultation with all relevant parties in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not ensure that people were protected against the risks associated with medicines management with particular regard to the delegation of medicines administration and effective auditing of medicines records. (Regulation 12(2)(g) Proper and safe management of medicines)