

Cheriton Care Centre Limited

Badbury Care Home

Inspection report

8 Weymouth Avenue
Dorchester
Dorset
DT1 2EN

Tel: 01305263365
Website: www.agincare-homes.com

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
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 the 27 and 28 October 2016 and was unannounced.

The service is registered to provide accommodation and residential or nursing care for up to 33 people. The service does not provide nursing care. At the time of our inspection the service was providing residential care to 27 older people some of whom were living with a dementia. The home is over two floors and bedrooms have en-suites. People have access to a number of sitting areas including a TV room and a music room. Access to the first floor is by stairs or passenger lift. The ground floor provides access to a secure garden area.

The service has 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.

People's identified risks in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. Assessments had not been reviewed regularly and when referrals had been made to health practitioners these had not been followed up. Food and drink charts were being completed but the information was not being reviewed to establish people's risk of malnutrition. Equipment was in place to support people at risk of skin damage but this was not being used correctly. Staff did not always have up to date information about changes to people's risks.

Auditing systems were in place but they had not always recognised areas that needed improvement. When areas had been identified actions had been taken to improve outcomes for people.

People, their relatives and visiting professionals told us there were not always enough staff to support people in a timely way particularly at weekends. Staffing hours had been assessed using a dependency tool and were higher than the tool calculated. However this was not reflective of people's experiences. We have made a recommendation about staffing levels.

People were supported by staff that had been recruited safely and had been trained to recognise any unsafe practice or potential abuse and understood their role in reporting this. Staff received an induction and ongoing training that enabled them to carry out their roles effectively. Staff felt supported in their roles and had regular supervision. Opportunities were available for staff's personal development.

People's medicines were ordered, stored and administered safely by competent staff that had completed medicine administration training. People's prescribed creams were being administered but not always recorded correctly. People had access to healthcare when it was needed.

Staff supported people's ability and choices about their day to day care and obtained consent in line with

the principles of the mental capacity act. People and their families knew how to make a complaint and felt they would be listened to and any actions needed would be taken.

Peoples eating and drinking needs were understood by care staff and the catering team and included specialist diets and allergies. The menu offered a variety of main meals and snacks and catered for individual likes and dislikes.

Care staff were kind, patient and friendly and respected people's privacy and dignity. They had a good understanding of peoples communication needs and used different techniques to ensure that people were involved in decisions. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them.

People had care and support plans that detailed how they wanted to be supported. People and their families were involved in decisions related to their care and advocacy services were available if needed. Reviews hadn't been consistently carried out albeit improvements had been made in the two months prior to our inspection. Handovers provided information to staff about changes to peoples care and support needs. A wide range of activities was available to people both inside the home and within the community. Staff respected the decisions people made on how they wished to spend their time. Where people were at risk of social isolation actions had been put in place to minimise this.

People, their families, staff and visiting professionals all described the registered manager as open and transparent. They felt they would listen to them and take any appropriate actions. Staff felt appreciated and understood their roles and responsibilities. They were included in discussions about future plans for the service and felt included in the service development.

You can see what action we told the provider to take at the back of the full version of the 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's identified risks in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks.

Staffing levels did not always meet the needs of people using the service.

People were supported by staff that had been recruited safely and understood how to recognise abuse and their role in reporting concerns.

People's medicines were ordered, stored and administered safely.

Is the service effective?

Good 

The service was effective.

Staff received an induction and on-going training that enabled them to carry out their roles effectively.

Staff supported people's ability and choices about their day to day care and obtained consent in line with the principles of the mental capacity act.

People had a choice of food and drinks available that reflected their likes and dislikes, allergies and specialist diets.

People had access to healthcare.

Is the service caring?

Good 

The service was caring.

Staff understood people's communication needs and used different techniques to enable people to be involved in decisions.

Staff had a good understanding of people's interests, likes and

dislikes.

People had their dignity and privacy respected.

Is the service responsive?

Good ●

The service was responsive.

People had individual care and support plans that detailed how they needed to be supported.

People, and when appropriate their families, were involved in decisions related to their care.

Where people were at risk of social isolation actions had been put in place to minimise this.

People had the opportunity to participate in activities both inside the home and within the community.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Auditing systems were in place but they did not always recognise areas that required improvements.

People, their families and staff had the opportunity to provide feedback about the service which led to positive outcomes.

Staff understood their roles and responsibilities and felt involved in the services development.

Badbury Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 27 and 28 October 2016 and was unannounced. It was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We also looked at information on their returned provider information return. 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.

During our inspection we spoke with seven people who used the service and three relatives. We spoke with the chief executive, quality lead, operations director, registered manager, deputy manager, care manager, five care workers and the chef. We reviewed six peoples care files with them and care workers to check they were up to date and correct. We checked four staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

After our inspection we spoke with two district nurses a member of the local authority safeguarding team and a social worker.

Is the service safe?

Our findings

When we last inspected the service in September 2015 we found a breach in regulation in relation to safe care and treatment. The provider had taken action to make improvements in areas such as medicines management and supporting people to eat safely. However, we found improvements were still required to ensure people's safety.

People's risks of malnutrition and dehydration were not managed safely. People had their risk of malnutrition assessed on admission to the service. The assessment tool considered a range of indicators that determined the level of risk a person had of malnutrition. In addition the registered manager kept a summary that collated the monthly weight of each person living at the service in order to oversee weight trends and any emerging risks. We identified people on the summary weight sheet who had been consistently losing weight and checked their care and support records. In one case there had been no review of the assessment tool between May and September 2016 although their weight loss had continued. Letters had been sent to GP's in May 2016 to notify them of the weight loss. Weight continued to fall but there were no records of following up the GP letters or seeking other specialist support. We spoke with the registered manager who agreed there had been no follow up action taken. They told us they would make this a priority to review and take any necessary actions.

Food and drink daily diaries were not in place for all people where a risk had been identified. For people where these were in place we found that although staff were entering information about the amount people were eating and drinking this information was not being used to inform assessments of risk to people. One person's diary showed over five days the amount they had drunk daily varied from 350mls to 750mls. The forms did not advise care workers what the minimum amount was that a person should drink although the form did have a mathematical calculation that could be used to determine this. We spoke with a social work manager who told us about their findings when they recently visited the service. "Food and drinks charts had not been reviewed or actions identified for people if they were not drinking". Care staff told us that the food and drink diaries went to the office each week to be reviewed by a senior person. In one person's room there were over 50 days' worth of information that had not been reviewed. We discussed this with the registered manager who agreed that the process for reviewing information about people's food and fluid intake had not been happening. They told us that a member of staff had recently become the nutritional lead and they would discuss with them a review of the process. There were no concerns from the community nurses about the reporting of urinary infection incidents which were within expected levels.

One person had been prescribed a nutritional supplement drink in April 2016 which had led to an increase in weight. The person's care record stated that they had an improved dietary intake and the supplement was no longer required. Weight records showed that the person continued to lose weight in June, July and August 2016. The GP discontinued the supplement in August 2016, however information regarding the person's continued weight loss had not been shared with the GP to inform their decision making. However we checked the care and support plan with the registered manager and it was dated May 2016. Care workers were not aware of the person's renewed weight loss. When we spoke with a care worker they told us "They were on a (supplementary drink) but doesn't have them now because before they weren't eating well."

The forms (diet and fluid diary) stopped when the (supplementary drink) stopped. They clear their plate. Fluids really good, they've put weight on". This meant that people were being supported by staff that did not always have up to date information about their risks.

One person had a safe swallowing plan in place as they had a risk of choking. We spoke to staff who demonstrated a good knowledge of how the person needed to be positioned when being supported with eating and the texture needed for their food and drinks.

People at risk of pressure damage to their skin were not having the risk effectively managed. People had their risk of skin damage assessed on admission to the service and where risks were identified actions were detailed in the person's care and support plan. Actions to minimise risk included people having specialist pressure relieving mattresses on their beds. In order to offer protection to people the air pressure must be set according to the person's weight. We checked mattress settings and found this was not happening. One person needed a setting of 55 and it was set at 90. Another person needed it to be set at 99 and it was set at 80. In some rooms a notice had been placed at the foot of peoples beds informing staff of the setting required. Settings were not set in line with the notices. We discussed this with the registered manager who acknowledged that mattresses had been set incorrectly. They told us they would speak with staff to reiterate the importance of checking mattresses each time a person was on their bed.

Some people needed to be supported by staff to change position regularly in order to relieve pressure on their skin. We checked people's re-positioning charts over a one week period and found these had been completed appropriately. Staff had been recording the times they had supported people to change position in line with the persons care and support plans.

Risks identified for people had not been consistently managed or actions taken in order to minimise the risks. This is a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by enough staff to meet their assessed needs in a timely way. We spoke with people, their families and professionals who visited the service and they told us that at times there were not enough staff. One person told us "I feel there are not enough staff. They are short-handed all the time. Always in a hurry. It affects my life here as you're left on your own morning to night just seeing somebody at meal times, breakfast, lunch and tea. The staff themselves do their best". A relative said "At weekends a particular problem. Food can come late. At times lunch can be 2pm and also very late breakfast, can be after 11am. The staff are not lazy just so busy". Another relative said "I feel they are short staffed mainly at weekends. Arrived about 3pm one day and mum shouting 'anybody there'. We rang her bell; she had three dirty cups of tea and a dinner plate in her room. The bell carried on ringing for at least 20 minutes". Another relative said "Have visited and clearly not enough staff. I have been here and people have been shouting for the loo and they have had to wait longer than they should. Weekends seem more of a problem. When I've been here at the weekend it seems you don't see any staff around". Another told us "Have sometimes wondered if there is enough staff. I feel it's been cut to the bone. It's not the fault of people at the coal face". We spoke with a community nurse who told us "One person had been shouting out 'I need water, I need a drink'. I spoke to a carer as they had been shouting for half an hour and they did apologise to both of us".

We spoke with care workers about staffing levels. One said "The call bell can ring for some time if you're with someone. I feel there's enough time to get people up and support with meals. Would be nice to have one more member of staff who can keep popping in and talking to people in their rooms. An audit carried out by the Operations Manager on the 25 October 2016 had highlighted that two non-emergency call bells had taken over 10 minutes to be answered. We discussed staffing levels and call bell response times with the

organisations quality lead. They showed us a call bell audit tool that was being reviewed at a policy review meeting the next day and would be piloted at Badbury. The registered manager during our inspection contacted the call bell system manufacturer to obtain information on how to produce data on response times from the system. They also told us they would start issuing a pager to senior staff in order that they could start to manage what was going on. They explained to us that a dependency tool had been used to determine the staffing hours needed based on people's assessed care and support needs. Staffing hours were higher than the suggested hours calculated by the dependency tool however this was not reflective of people's experiences.

We recommend that the service find out more about best practice in relation to staffing levels when supporting older people and the specialist needs of people with a dementia.

People were supported by staff that had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. Processes were in place to manage unsafe or poor practice.

People told us they felt safe living in the home. One person said "The staff are gentle. They don't do anything I don't want them to do". A relative told us "(My relative) is safe, there's no hitting, bullying, swearing at her. I get amazed at their level of patience". "Staff were aware of what constitutes abuse and the actions they would take if they suspected if someone was being abused. Staff were able to explain how to escalate any concerns about poor practice.

People's medicines were ordered, stored and administered safely by competent staff that had completed medicine administration training. We checked the medicine administration charts for people and they had been completed correctly other than for prescribed creams. The records included a body map showing staff where creams needed to be applied. We spoke to senior care staff who told us that the creams were applied every day but records did not consistently demonstrate this had happened. We looked at the medicines audit for September and creams had been recorded as 100% correct. The senior care worker told us they would remind care workers of the process.

A process was in place to record and monitor any accidents or incidents. Records showed us that the manager reviewed all accidents and incidents. Any actions needed to minimise any further risks had been taken and included referrals to a falls clinic and to GP's. People had personal evacuation plans in place so that in the event of an emergency their individual needs would be understood.

Is the service effective?

Our findings

Staff received an induction and on-going training that enabled them to carry out their roles effectively. New staff completed the Care Certificate induction standards. The Care Certificate is a national induction programme for people working in health and social care who do not already have relevant training. We spoke with one care worker who told us "For my induction I went to the headquarters and did training. It included moving and handling, dignity and safeguarding. There's a trainer and we have to complete workbooks. Manual handling was really good; we have all the equipment we need. The equipment is really good". We spoke with the care manager who told us their induction had included supervision skills, problem solving and company forms and procedures.

Staff told us they felt supported. One care worker told us "I've just had supervision with the care manager. It's usually planned every two to three months. If anything is wrong there is always (registered manager) in the office". The quality manager told us that a course had been planned for staff about managing bereavement. This had arisen from a request by staff who wanted to better support families before and after bereavement. Staff had opportunities for personal development. We spoke with one care worker who said "I'm half way through my level 2 diploma in health and social care; I'm really enjoying it".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this 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. The service was working within the principles of the MCA. Staff supported people's ability and choices about their day to day care. Most people living in the home were able to make decisions about their care and they did so throughout our inspection. We observed staff seeking consent before supporting people with care and giving people time to make a decision. We saw on care files consent forms had been signed by people in relation to aspects of their care. When people had not had the capacity to sign themselves families had been involved in consenting. When decisions had been made in a person's best interest they had included family and professionals who had knowledge of the person's history. One person had a condition attached to their DoLS authorisation. The condition related to access into the community. Staff were aware of the condition and working with the person's social worker to access a specialist wheelchair.

People and their families told us that the food was good and there was always plenty of choice. "The food is generally good. There are good choices and staff know what my favourite things are". Another person said

"You get plenty of choice". Breakfasts I like; I asked for a fry up and get one every morning". We visited the kitchen and spoke with the chef. The information they held about peoples dietary needs, likes and dislikes reflected what was in peoples care and support plans. The information included people who were having their food fortified to support them gain or maintain their weight. One person had a food allergy and they explained to us how this was accommodated when purchasing and preparing food. The menu planner included choices of hot and cold food at each serving. They said "Lots of residents like tea and toast for breakfast but we do hot breakfasts to order. Staff go around offering choices for lunch after people have had breakfast". We spoke with a relative who told us "There's plenty of food, the kitchen are really amenable. You just stick your head into the kitchen and there's always something available, it's never a problem".

People had access to healthcare when it was needed. Records were kept of professional visits and included the GP, district nurses, occupational therapists and chiropodists.

Is the service caring?

Our findings

When we last inspected the service in September 2015 we found that staff demonstrated empathy and knew some of the people well but they showed little insight into people's social and emotional needs. We asked the provider to take action which they had completed.

People and their families described the care staff as kind, patient and friendly. We observed staff encouraging people to carry out tasks for themselves. One person was cautious about walking and the care worker spent time walking beside them and quietly motivating them to go a little further. Staff were mindful of the temperature and offered to fetch warmer clothing for people who were not able to go and get it themselves. Staff also knew the informal names people had chosen to be addressed by and used these appropriately.

One person had problems expressing themselves verbally. Pictures were in their room that included general needs such as meals, drinks and the toilet but also contained pictures that were personal to their individual care needs. A care worker told us "I've got to know (the person) quite well so can usually understand what they are asking for but sometimes it is more difficult and I use the pictures". People were supported to maintain their glasses and hearing aids in good repair in order to aid communication. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. A relative we spoke with said "The girls are so lovely and I feel they know my (relative) so well".

People and their families told us they felt involved in decisions. One relative told us "The girls chat to me and tell me what (relative) has been up to. They went on a bus trip last week. One of the girls encouraged them which I am really pleased about". People were given information about advocacy services that could support them with decision making. We read minutes of resident/relative meetings where discussions had included the building renovation, making complaints, open day ideas and items for a monthly newsletter.

People had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. People's clothes and personal space were clean and reflected a person's individuality.

Is the service responsive?

Our findings

When we last inspected in September 2015 we found breaches in regulation relating to maintaining people's care records and person-centred care. At this inspection we found that the provider had made improvements.

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs, how they were able to communicate and the actions staff needed to take to support people. Reviews of care and support plans had not consistently taken place each month. We discussed this with the registered manager who told us this had been identified in the last audits and actioned. Files had been reviewed in September and October 2016. One relative told us "I've been offered the opportunity to get involved in reviews but not been able to make them. The staff are very good at keeping in touch". Each person's file contained a 'grab sheet'. This contained information that could be transferred with the person in the case of an emergency. It included emergency contact details; medical history, allergies, DoLs status and any do not attempt resuscitation decisions.

Staff told us that through handovers information was shared about changes to people's care needs. One care worker said "There is a handover sheet and it is a summary of people's needs. It's really handy when you first start as it has all the information about people's key needs detailed". We spoke with a social care manager who told us "The handover has been updated and is more robust". Staff completed a daily record for each person which included comments about people's mobility, personal care, activities and any visits.

People who were at risk of social isolation had a care and support plan detailing actions needed to reduce this. One detailed the radio channel a person liked to listen to and to ensure any visiting animals were taken to see them as they had always loved animals. We spoke with a care worker who told us "When people are on their own carers when their available will go and sit with them and keep them company". A social care manager told us "There is a befriending lady who visits two days a week and spends time with people in their rooms who are in bed. They read to them, do manicures, talk with them". We spoke with a relative who told us "(Relative) is a loner. They go down for breakfast, but staff have to persuade her as they prefer their own room. In the summer some days they spent some days in the garden enjoying meals and games".

We spoke with one person who said "There are things I can join in with. I went to the last one, its music today. I go along as it breaks up the day". A relative told us "There are always things going on. There are always activities. One lady enjoys flower arranging. They were out a lot in the summer doing things. If you want to you can have a fairly active life".

Staff had been collecting information from people and their families and creating pen pictures of people's life's. Activities had been arranged to reflect people's interests. One person was attending a regular social event in the community they had always enjoyed. Staff told us that each day at handover a care worker is allocated activities and arranges something for the afternoon. This included quizzes, word games and old movies. We observed people enjoying a quiz with staff that prompted a lot of laughter and conversation.

We read resident meeting minutes and activities were discussed and ideas had been shared. People had feedback that they had enjoyed trips out in a mini bus and had asked for more of these. Trips had been taking place monthly and had included lunches out in the community, trips to the local town and garden centres.

A complaints procedure was in place and people and their families told us they knew how to make a complaint. One person said "I get on with most of the staff. If I had a complaint I would go to the person on duty and I do feel I would be listened too". One relative told us about a complaint they had made, "I was met on site and the issues I raised were actioned straight away". People told us and we read about complaints in relation to peoples laundry. We saw that in response laundry staff hours had been increased to address the issues.

Is the service well-led?

Our findings

The auditing systems in place and monitored by the registered and operations manager had not always recognised areas that needed improvement to ensure the best outcomes for people. This included areas of risk in relation to peoples weight and skin care identified at this inspection.

Systems to monitor peoples nutrition and hydration were not effective. The provider had produced an action plan following our inspection in September 2015 which detailed what they would be putting in place to improve the reviewing and actioning of identified risks to people. The action plan included measures for checking that this happened and was sustained.

We found that although a process had been put in place by the registered manager that provided information on peoples monthly weights this additional checking had not been used to identify emerging risks or to check that any appropriate actions were being taken. Some people were on diet and fluid charts so that their intake of food and drink could be measured and any emerging risks of dehydration or malnutrition identified and actioned. Care workers told us they understood that the information was reviewed each week by senior staff but we spoke with the registered manager and this was not taking place.

Systems had been put in place to monitor peoples risk of skin damage. Actions to minimise risk had included providing people with specialist pressure relieving mattresses. In some rooms we saw notices stating the correct setting a mattress needed to be set at to ensure people had the maximum protection. We spoke with care workers who understood that mattresses needed to be set to reflect an individuals weight. However we found that people's pressure relieving mattresses were not always set appropriately. No auditing of mattress settings had taken place to ensure that the measures introduced to protect people were taking place.

Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare. This is a breach of Regulation 17 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that where areas for improvement had been identified actions had been taken to improve outcomes for people. These had included monitoring accident/incident reports, medicine administration and record keeping. The registered manager had submitted a provider information return prior to our inspection that showed evidence that they had a clear idea of where they were achieving well and where they could improve people's experience of care. A quality assurance survey took place annually and people had the opportunity to provide feedback at residents meetings. The information gathered was used to improve outcomes for people. This had included additional laundry hours and an increase in visits to the community. The district nurses told us that communication between the home and the surgery was not always good as the request for a nursing visits are not always co-ordinated meaning they have to return to the home again later in the day. They had raised this with the registered manager and were having a

meeting to discuss a more organised approach.

People, their relatives and staff all described the registered manager as open and positive. One person said "He's a good bloke and will always give you time". A relative told us "(Registered Manager) has been on top of work (refurbishment). He gives us regular updates and if you raise an issue with him he gets it sorted. Always got time. Staff seem to respect him. He has been fantastic and made the difference". We spoke with staff who spoke positively about the management. One said "(Registered manager and deputy) are approachable. They have an open door; you can go in with any queries". Another said "If I raise a concern about a resident they get on the case and look at it and change it". We spoke with the local authority quality improvement team who told us "(Registered manager showed leadership keeping people informed about the refurbishment. A social care manager described the registered manager as "Transparent and very good".

The Manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

When we spoke with staff they understood their roles and had been involved in discussions about future plans for the service. This had included introducing a key worker role and establishing lead roles in key areas such as nutrition, infection control and medicines. A care worker told us about the planned key worker system. They said "It will really benefit people especially those who don't have family members". Staff talked about their jobs, the organisation and the people they were supporting enthusiastically. We read staff meeting minutes and staff had talked openly about relationships with other staff, about ideas for improving handover, team building and a carer of the month scheme. A quarterly newsletter had been produced and included topics such as activities and staff training.

The organisation was working with a local college and had set up an academy with the support of Skills for Care. Skills for Care is the strategic body for workforce development in adult social care in England. The chief executive told us how the organisation were mapping qualifications against jobs so that people had a clear vision of the career opportunities available to them and felt this would have a positive impact on recruitment of staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's identified risks in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks.

The enforcement action we took:

Imposed conditions on the providers registration certificate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing systems had not recognised areas that required improvements to ensure safe care of people.

The enforcement action we took:

Imposed conditions on the providers registration certificate.