Wayside Care Home Limited

Wayside Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 February and 2 March 2016 and was unannounced. There were no concerns at the last inspection of September 2013. Wayside Residential Care Home provides accommodation for up to 10 older people. At the time of our visit there were 10 people living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager is also the joint registered provider and owner of the service.

People were "very happy" living at Wayside and we received positive comments about their views and experiences during our visits. Despite the areas for improvement, people were "very satisfied" and "staff always did the best they could". Comments included, "The registered manager and staff work very hard and never let me down", "It's quiet and peaceful, I am so happy" and "The owners are impressive".

Despite the views of people and their relatives, improvements were required in a number of areas. People were not protected from the risk of cross infection. This was because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment.

Although staff had access to a variety of training topics, we could not be satisfied that the training was always effective. Staff did not always have the knowledge and skills they needed to carry out their roles effectively.

Monitoring the quality of the service was not always effective. People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

Staff were knowledgeable in safeguarding procedures and how to identify and report abuse. People were supported by the recruitment policy and practices to help ensure that staff were suitable. The registered manager and staff were able to demonstrate there were sufficient numbers of staff with a combined skill mix on each shift. Staff confirmed they were supported by the provider and the registered manager at all times.

People were helped to exercise choices and control over their lives wherever possible. Where people lacked capacity to make decisions Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented to ensure that people who could not make decisions for themselves were protected.

People received a varied nutritious diet, suited to individual preferences and requirements. Mealtimes were flexible and taken in a setting where people chose. Staff took prompt action when people required access to community services and expert treatment or advice.

People enjoyed receiving visitors and had made "friends" with people they lived with. They were relaxed in each other's company. Staff had a good awareness of individuals' needs and treated people kindly. References were made by relatives and staff about the "family atmosphere and homely feel". Staff were knowledgeable about everyone they supported and it was clear they had built up relationships based on trust and respect for each other.

People moved into the service only when a full assessment had been completed and the registered manager was sure they could fully meet a person's needs. People's needs were assessed, monitored and evaluated. This ensured information and care records were up to date and reflected the support people wanted and required.

The service was important to the provider and registered manager and they wanted the best for people. There was an emphasis on teamwork amongst all staff at all levels.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not protected from the risk of cross infection because appropriate guidance had not been followed. Some areas of the home were not clean and hygienic.

Staff had received training in safeguarding so they would recognise abuse and know what to do if they had any concerns.

People received care from staff who took steps to protect them from unnecessary harm. Risks had been appropriately assessed and staff had been provided with clear guidance on the management of identified risks.

There were enough staff on duty to support people safely.

People were protected through the homes recruitment procedures. These procedures helped ensure staff were suitable to work with vulnerable people.

People were protected against the risks associated with unsafe use and management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were encouraged and keen to learn new skills and increase their knowledge and understanding. However training was not always sufficient or fully understood by staff.

Staff were confident when supporting people unable to make choices themselves, to make decisions in their best interests in line with the Mental Capacity Act 2005.

People had access to a healthy diet, taking into account their nutritional requirements and personal preferences.

The service recognised the importance of seeking advice from community health and social care professionals so that people's health and wellbeing was promoted and protected.

Is the service caring?

Good

The service was caring.

The providers, registered manager and staff were caring and kind and they wanted people to experience good quality care.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was partially responsive but improvements were required.

Staff identified how people wished to be supported so that it was personalised.

People were provided with activities. Activities and stimulation for people with dementia needed to be further explored.

People were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Requires Improvement

The service was not always well led and improvements were required.

Quality monitoring systems were in place but they were not always effective. Systems did not drive improvement in the quality and safety in some of the services provided, particularly around the environment.

People who used the service felt supported by the registered manager

Procedures were in place for recording and managing complaints, safeguarding concerns, incidents and accidents.

Wayside Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This service was previously inspected on 25 September 2013. At that time we found there were no breaches in regulations. This inspection took place on 29 February and 2 March 2016 and was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Before the inspection, we asked 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 planned to make. We use the PIR to assist in our planning of the inspection. Unfortunately there was a technical fault with the form and the provider had been unable to submit this.

During our visit we met and spoke with all 10 people living at the home and two relatives. We spent time with the registered manager, nominated individual, and five staff. On 3 March we telephoned and spoke with a further two relatives and three staff. We looked at four people's care records, together with other records relating to their care and the running of the service. This included three staff employment records, policies and procedures, audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. On the first day of our inspection we looked at the environment. People were not protected from the risks associated with cross infection because appropriate guidance had not been followed. Although people and relatives felt the home was "clean and fresh", we saw evidence where parts of the home were not clean. In some areas the interior fixtures, fittings and furnishings were not in good physical repair and could not be effectively cleaned. Although surface areas were clean, deep cleaning was required in some parts of the home.

Tiles in the kitchen, bathroom and toilets were broken and some had fallen off the wall and had exposed the plaster. Laminate had peeled off kitchen units which revealed rough chipboard. The flooring in the main bathroom and kitchen was ripped and lifting from the floor. Plastic coating on the frames of the commodes had started to peel away to expose rust. Effective cleaning was compromised in these areas and could harbour germs.

There were two occasions where staff were not using correct protective equipment when disposing of dirty laundry and continence pads. People's commode pans did not have lids, which meant staff carried used pans through the home without being covered. One toilet which was regularly used by people did not have hand washing facilities. This room had a strong smell of urine. We raised these concerns with the registered manager. On the second day of our inspection a plumber was in the home to provide quotes for hand washing facilities. The registered manager had also ordered new commodes to replace those that were no longer suitable.

Infection control audits had not been completed. The provider and registered manager were not following the Department of Health, Code of Practice on the prevention and control of infections, or other relevant guidance.

This was a breach of Regulation 12 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

People and their relatives felt they were in 'safe hands'. Comments included "I feel reassured, knowing my relative is being cared for", "It's good to know there is someone here 24 hours a day" and "My relative had several falls prior to living at Wayside, the staff have protected him and he has not fallen once". People had keys to a locker to keep their personal belongings safe and they were given the option to have a key to their rooms.

Staff were kind and protective, they wanted people to be happy. Staff confirmed they had received safeguarding training. Safeguarding policies and procedures were available and staff signed to say they had read and understood them. Information was available for staff about who to contact should they suspect that abuse had occurred. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they would notify included the local authority, CQC and the police.

The registered manager and staff understood their responsibilities for reporting accidents, incidents or concerns. Written accident and incident documentation contained a good level of detail including the lead up to events, what had happened and what action had been taken. Any injuries sustained were recorded on body maps and monitored for healing.

Staff encouraged people to live as independently as possible and recognised this could expose people to some degree of risk. People were supported to take risks balanced on their safety and their health care needs. The registered manager gave us a recent example where this was demonstrated. One person had discussed with the registered manager on their recent admission to the home, that they were no longer confident to manage their own medicines. Following an assessment and support from the registered manager, the person did retain a level of independence in which they felt safe with, by continuing to administer their own eye drops.

Staff knew about specific risks relating to people's health and well-being and how to respond to these. This included risks associated with weight loss, maintaining skin integrity and difficulty with swallowing and potential choking risks. People's records provided staff with information about these risks and the action staff should take to reduce these.

People, relatives and staff confirmed there were sufficient numbers of staff on duty. Comments included, "I can always find a member of staff quickly", "I don't ever feel rushed when supporting people" and "Staff presence is good even on the weekends, I think it's great to see the manager helping and supporting people". During the inspection the atmosphere was calm and staff did not appear to be rushed, they responded promptly to people's requests for support.

The staffing levels did not alter if occupancy reduced. If people's needs increased in the short term due to illness or in the longer term due to end of life care, the staffing levels were increased. The registered manager told us they had previously provided one to one support for people with dementia, whose behaviours had changed. This support had relieved people's anxiety and helped keep them and those around them safe from harm.

Over the past year half of the workforce (six staff) had left Wayside to pursue other roles and for personal reasons. This had been managed well and staffing levels had been sustained, whilst the registered manager continued with their recruitment programme. The same two care staff from an agency had been covering shifts so that there was consistency for people. The provider and registered manager both had a nurse/care background and often worked alongside staff to support them with their knowledge and skills.

Staff files evidenced that safe recruitment procedures were followed at all times. Appropriate pre-employment checks had been completed and written references were validated. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant has had any past convictions that may prevent them from working with vulnerable people.

Policies, procedures, records and practices demonstrated medicines were managed safely. There had been no significant errors involving medicines in the last 12 months. Staff completed safe medicine administration training before they were able to support people with their medicines. Staff were observed on all medication rounds until they felt confident and competent to do this alone. The registered manager also completed practical competency reviews with all staff to ensure best practice was being followed.

Requires Improvement

Is the service effective?

Our findings

The service was partially effective but improvements were required to ensure staff training was meaningful and equipped staff with the right skills and knowledge. The effectiveness of infection control training needed to be reviewed following the unsafe practices we identified during this inspection. Staff had received training in dignity and respect, person centred care and dementia awareness; however we saw certain practices that questioned their understanding around these areas.

On the first day of our inspection we saw seven out of 10 ten people sat in the lounge. They appeared to be comfortable, however there was very little stimulation to occupy them, the television was on but people didn't seem interested. People were either asleep or staring into space. One person was anxious and worried. People did not have access to resources that would engage them, calm or relax them, excite or interest them. We spoke with the registered manager and staff about simple solutions for example memory/rummage boxes, adult colouring books, jigsaws, reminiscence books or objects, and photograph albums.

When we returned on the second day of our inspection a large box had appeared in the lounge full of toys suitable for babies and toddlers. People and their visitors may find these items demeaning and confusing. Research has shown that certain "toy therapy" has greatly benefited people with dementia. However the training staff had received had not equipped them with this knowledge. The toys they brought in were not age appropriate and although some of the items may interest people initially, they had not been consulted and appropriate guidance had not been sought.

We could not be satisfied that training in dignity and respect was sufficient or fully understood. The registered manager and staff had failed to recognise where certain areas in the home and some practices compromised dignity and respect. When we were being shown around people's rooms we saw labels on their drawers referencing where items of clothing "belonged" and they had used words such as "knickers". This practice is considered institutional and not person centred. The registered manager confirmed the labels were likely to have been placed on the drawers for "residents" who had previously lived in the home and had just remained there. Some of the terminology used in peoples written records was not suitable and included phrases such as people need "toileting" and "feeding" , rather than people need "assistance with continence" and at "mealtimes".

Other areas where there were shortfalls around aspects of dignity and respect included the environment and soft furnishings. People were provided with towels that were threadbare and fraying. Every curtain hung throughout the home did not have enough curtain rings or hooks, so they did not hang properly or pull together effectively. Some bedroom furniture was in need of repair or replacement; a wardrobe door had been pulled off and not replaced.

This was a breach of Regulation 18 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

New staff had an induction programme to complete when they started working at the home. The programme consisted of 15 modules to be completed within three months and was in line with the new Care Certificate introduced for all care providers on 1st April 2015. A mentor system was also in place where all new staff were linked with and shadowed by a senior staff member during shifts. This was to assist with continued training throughout the induction process and to consolidate their learning.

Staff were encouraged and supported to increase their skills and gain professional qualifications. There was an expectation that all staff would undertake a diploma in health and social care at level two or three (formerly called a National Vocational Qualification).

In addition to mandatory courses, staff studied additional topics to help them understand the conditions and illnesses of the people they cared for. This included stroke awareness, Parkinson's, and diabetes. The registered manager had accessed training resources from a new training provider. The initial feedback about the training was positive from staff. Comments included, "The courses are quite detailed and I am enjoying them" and "The workbooks are thorough and we support each other to work through them.

Staff felt they were supported by the registered manager, team leaders and other colleagues. Additional support/supervision was provided on an individual basis and these sessions were formally recorded. Supervisions supported staff to discuss what was going well and where things could improve, they discussed people they cared for and any professional development and training they would like to explore. There were quarterly staff meetings as an additional support network, where they shared their knowledge, ideas, views and experiences.

The registered manager was a qualified mental health nurse and was very knowledgeable about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

People's legal rights were respected and any restrictions were kept to a minimum using the least restrictive option. Where applications had been authorised to restrict people of their liberty under the DoLS it was to keep them safe from possible harm. There was a clear account about why referrals had been made and how a person had been supported through the process and by whom. This included GP's, best interest assessors and or independent advocates. There were systems in place to alert the registered manager when DoLS would expire and needed to be re-applied for.

There were no restrictive practices and daily routines were flexible. People were moving freely around their home, spending time together and with staff and visitors. They chose to spend time in the lounge, the dining room and their own rooms.

People told us they "liked the food and they chose what they had to eat". One person said, "All the food is very good; the lamb casserole was tender and tasty today". People enjoyed their meal and one person had "seconds". People were asked after each mealtime if they had enjoyed their food. Menus reflected seasonal trends and meals that people had chosen were traditional favourites.

Mealtimes were flexible wherever possible and people were supported if they wished to receive meals in their rooms. The dining room was popular with people and they enjoyed dining together. Where people required assistance, this was provided with a peaceful, calm approach, at their own pace, sitting at the same level, with clothes protected where requested.

Weights were checked monthly but frequency increased if people were considered at risk. The registered manager gave us examples of when referrals had been made to specialist advisors when required. This included speech and language therapy when swallow was compromised and GP's and dieticians when there were concerns regarding people's food intake and weights.

The registered manager and staff recognised the importance of seeking expert advice from community health and social care professionals so that people's health and wellbeing was promoted and protected. The home ensured that everyone had prompt and effective access to primary care including preventative screening and vaccinations, routine checks, GP call outs and access to emergency services. People were supported to register with GP's and dentists of their own choice. Referrals had been made to speech and language therapists and community dieticians. Opticians and dentists were accessed to provide regular check-ups and treatment where necessary. One person told us, "I haven't been here long but my hearing aids have been fixed already".

Communication systems were in place to help promote effective discussions between staff so they were aware of any changes for people in their care. This included daily handovers, staff meetings and written daily records. Keyworkers wrote a monthly account with the people they supported. These accounts also provided a good level of detail for all staff to read, they told a story and informed staff about what had happened during the month.

Good

Is the service caring?

Our findings

The service was caring. We were introduced to people throughout our visits and we spent time observing them in their home. The atmosphere was relaxed and people appeared comfortable and confident in their surroundings. We received positive comments about staff which included, "I am very settled and the carers are so nice", "The staff are wonderful they always have time for me" and "They are a smashing bunch, I am spoilt".

We asked staff what they thought they did well and what they were proud of. Comments included, "It's a small home and I think that's the key, care is individualised", "I enjoy working here and I think people are cared for well. I hope they feel important and special" and "I couldn't work here if I didn't think people received good care. We all really want what's best for people".

During our visits we saw staff demonstrating acts of patience and kindness. One person who had dementia was becoming increasingly anxious because they thought they had lost their coat. A member of staff repeatedly offered words of reassurance to explain this was not the case. The staff member retrieved the persons coat from their room so that the person had something visual to see in order to relieve their fears.

The registered manager spoke with us about the keyworker role and how this enhanced a personalised approach. Staff were descriptive about the people they supported and their knowledge of needs both physically and emotionally was good. They told us what made people happy or sad and how staff considered physical signs that would tell them how a person was feeling. Care documentation confirmed this. People were asked what made them upset or angry. Comments included, "Cruelty", "Invading my personal space", "People shouting" and "Not being able to do things for myself". Staff had considered what things would help people if they became upset or anxious. In addition to diversional strategies, written records contained words such as "use gentle tones", "speak calmly" and "be sensitive".

People were smartly dressed and looked well cared for. They were supported with personal grooming and staff had maintained those things that were important to them prior to moving in to the home. This included preferred style of clothes that were clean and ironed, shaving, manicures, helping people to fasten their jewellery and weekly sessions with a hairdresser. Care documentation provided staff with personal preferences so that choices were promoted. Examples included, "I prefer to wear casual clothes, trousers and jumpers" and "I like to use toiletries that smell of lavender".

Staff provided us with a good level of detail about people's lives prior to moving in including family support and existing relationships. One recently recruited member of staff told us, "I found speaking with staff very useful when I wanted to know about family members, how often they visited, where they lived and other useful information".

Every effort was made to ensure relationships remained important. Some family members lived abroad or in other parts of the country. People were supported to have contact with them through telephone conversations and video calling. Visitors were welcome any time with the consent from the person they were

visiting. People saw family and friends in the privacy of their own rooms or in communal areas. Invites were sent to everyone so they could join in any celebrations or events at the home. Relatives told us, "I enjoy visiting and feel welcome. Staff always offer a nice cup of tea", "The staff are very caring, we found the home by accident and couldn't be happier, visiting gives us quality time together" and "My relative appears very happy when I visit".

Requires Improvement

Is the service responsive?

Our findings

During our visits we saw people being cared for and supported in accordance with their individual wishes. One person told us, "The manager asked me lots of questions before I moved here. Staff have been very keen to find out what I like, they have been very thorough".

The registered manager completed an assessment for those people who were considering moving in to the service. Every effort was made to ensure that significant people were part of the process including family, hospital staff, GP's and social workers. The information gathered supported the registered manager and prospective "resident" to make a decision as to whether the service was suitable and their needs could be met.

The assessments assisted staff to develop care plans based on individual needs; they were reviewed and further developed during the first four weeks of admission. People and their relatives were supported through this process by the registered manager.

Plans captured an approach to care that included the support people required for physical and emotional well-being. They were personalised and included information on people's life experiences, interests, hobbies and likes and dislikes. There was specific, information about behaviours, personalities and personal backgrounds. This included how people preferred to be addressed; the level of assistance required and preferred routines. Preferred night time routines had been considered and records reflected that people had been asked what would make them happy and feel safe. This covered aspects such as what time they wanted to go to bed, closing bedroom doors, whether people preferred a light on or a window open.

Care staff were responsible for arranging and providing activities on a daily basis. Although some activities were provided, the programme and types of stimulation available for people needed to be reviewed. This was because we had previously identified that staff lacked the knowledge and skills required to support people with dementia. Activities that were provided included arts and crafts, arm chair exercises, one to one time and movie afternoons. People chose how to relax, including watching television, listening to music, reading newspapers, going out with family and receiving visitors. Themed events and parties took place for example, Easter, Valentine's Day and Halloween. Musical entertainers visited the home twice a month. Church members visited the home either to provide a small service or to spend time with people individually.

We recommend that the service seek advice and guidance from a reputable source, about providing meaningful activities and stimulation for those people living with dementia.

The service had a complaints and comments policy in place. People and their families were given a copy of the complaints procedure and policy on admission. They were able to raise concerns and were confident their concerns would be acted on. Comments included, "I'm going to be honest there has never been anything to complain about" and "I haven't had to complain but the manager and staff are so approachable they would address any concerns if we had any". There had not been any complaints in the last year.

The registered manager encouraged people to express concerns or anxieties so they could be dealt with promptly. This approach helped prevent concerns escalating to formal complaints and relieved any anxiety that people may be feeling. They also spent time around the home and saw people every day to see how they were. This approach had helped form relationships with people where they felt confident to express their views. It was evident when we were accompanied around the home that the registered manager knew people well and they were comfortable and relaxed in their company. One relative told us, "The managers daily presence really helps, it's so easy to talk to them, communication is the key, we are always kept informed which stops us from worrying". Things that had "worried" people or made them "unhappy" were documented in the daily records and provided information about how they had been dealt with. This information was also shared with staff in shift handovers.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led and improvements were required. Although the registered manager monitored the service by completing audits, some were not detailed enough. When actions required had been identified, these were not dealt with promptly. Infection control audits were not completed and the registered provider had not recognised the risks that we had identified during this inspection.

The provider had made repeated applications to extend the home. The process had taken longer than anticipated and because of this some parts of the home that required refurbishment and decoration had been put on hold. This included the current kitchen, which in the new plans would be moved to the proposed extension. In the interim the provider had failed to make short term plans to ensure parts of the kitchen were clean and hygienic and free from infection control risks.

The premises audit completed in January 2016 had identified some areas in the home that required repair, replacement or redecoration. In addition to the homes audit, we identified where further improvements were required in the home. This included replacement flooring in several bedrooms, plaster repairs to walls and ceilings following water damage, radiator covers and broken bedroom furniture repairs, missing skirting boards and painting and decorating.

There were no action plans or timescales detailing when the work would be completed by. The provider did not employ a regular maintenance person. The registered manager told us the person they used for maintenance purposes was on long term leave and out of the country. The registered manager had not found an alternative solution in the meantime so that works could be carried out.

The main bathroom was in poor repair, tiles were cracked and some had fallen off the wall, the flooring was damaged and ripped, the bath panel was cracked and broken. Needs of people who had a diagnosis of dementia had not been considered with regards to the environment. Bathroom walls, bathroom suite, toilet seat lids and handrails were all white. This meant that there was no contrast of colours and they could not easily be identified as to their use. This would help people find their way around more independently. Published best practice guidance by the Social Care Institute for Excellence identifies the need for a suitably designed environment to help people maintain their dignity and independence.

This was a breach of Regulation 17 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

We asked people, relatives and staff their thoughts about the environment. Comments included, "It does look tired in places", "I have visited lovely new homes but it doesn't mean the care will be good", "A lick of paint would be good but I cannot fault the care" and "I can live with the decoration but other things do require attention".

People were complimentary about the registered manager and their "dedication to the home". Comments

included, "The managers presence is greatly appreciated, I'm always impressed with the owners they are good people", "The manager is very calming and easy to approach, they always seem well informed and tell me exactly what's been happening with my relative" and "We were absolutely delighted to find this home, the manager has been impressive, it was a lucky find".

The quality of services was assessed by providing people and their relative's surveys to complete every year. People were positive about the home and services provided. The written comments received from recent surveys stated, "My family are very pleased with care provided and Wayside is a very good home", "We can talk to the manager and staff anytime. We always receive regular updates" and "The staff are always approachable".

Additional systems were in place to monitor and evaluate services provided in the home. The registered manager reviewed complaints, incidents, accidents and notifications. This was so they could analyse and identify trends and risks to prevent re-occurrences and improve quality.

The registered manager was knowledgeable about the people in their care. They promoted and encouraged open communication amongst everyone who used the service. There were good relationships between people, relatives and staff, and this supported good communication on a day to day basis. Other methods of communication included meetings for people, their relatives and staff. The minutes of the meetings gave details about what was discussed and provided information of any action that was required.

An outside auditor visited annually to assess health and safety in the home. Weekly and monthly checks took place and covered fire alarms, water temperatures and emergency lighting. Fire tests were carried out so that everyone who used the service was aware of safe practice in the event of a fire. The Avon fire brigade visited the home in 2015 and no concerns were identified.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with cross infection and appropriate guidance had not been sought or followed. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems did not drive improvement in the quality and safety in some of the services provided, particularly around the infection control and the environment. Regulation 17 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training was not always effective and did not equip staff with the necessary skills to perform their roles. Regulation 18 (2) (a)