Cavendish Close Limited

The Close Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected The Close Care Home on 6 January 2016. The Close Care Home provides residential and nursing care for people with a range of conditions, this includes people with dementia. The home offers a service for up to 90 people. At the time of our visit 72 people were using the service. This was an unannounced inspection.
At our inspection on 14 May 2015 we found the service did not always support people in line with the principles of the Mental Capacity Act 2005 (MCA). We also found medicines were not always managed safely. Following our inspection we asked the provider to send us an action plan telling us how they would meet the regulations.
At this inspection we found improvements had been made and the provider had taken steps to meet the required standard. However we found another area where improvements were required.

Since our last inspection the provider had completely restructured the management team in the home. Three home managers had been appointed; this consisted of two clinical home managers and a non-clinical manager. One of the clinical managers had applied to CQC to become a registered manager. The second clinical manager was in the process of submitting their application. 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, relatives and staff were complimentary about the new management team. There was a calm, relaxed atmosphere throughout the day. The management team were approachable and promoted an open culture that put people at the centre of everything that happened in the home.

Health and social care professionals were positive about the changes made at the home and care provided. They were complimentary about the skills and knowledge of the care team.

Care records contained information relating to people's preferences and people were given choices about all aspects of their care. However care records were not always up to date and fully completed.

There was a range of activities available to people throughout the day, these included both individual and group activities. People enjoyed the activities and individual interests were identified to ensure people had access to activities that interested them.

People were extremely complimentary about the food and were given choices at each meal. Pictorial menus were available to support people to make choices. Food looked appetising and people were supported to eat and drink in a respectful, dignified manner.

Staff felt well supported and were positive about changes made to one to one meetings with their managers. The changes meant staff were encouraged to identify their own development needs. Staff were

knowledgeable about the people they supported and had a caring attitude.

The provider was committed to improving the quality of care at The Close. A comprehensive audit had been carried out by an independent consultant to identify areas where improvements could be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely.

Risks to people were identified and plans were in place to manage the risks.

Checks were carried out for new staff to ensure they were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.
The service worked to the principles of the Mental capacity Act 2005 (MCA)

People received sufficient food and drink to meet their needs. Food was appetising and people were complimentary about the standard of the food.

People were supported to access health services when required. Health professionals were positive about the responsiveness of the service in referring people to health services.

Is the service caring?

Good

The service was caring.
People benefitted from staff who were kind and caring.

People were treated with dignity and respect.

People were involved in decisions about their care and staff explained before providing support.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's records were not always fully completed and accurate.

People benefitted from a range of activities that interested them.

People knew how to make complaints and were confident to do so. Complaints were dealt with to the satisfaction of people making complaints.

Is the service well-led?

Good

The service was well-led.

The management team were approachable and knew people well.

There was an open culture that focused on the needs of people living at the service.

There were quality assurance processes in place to enable the service to continually improve.

The Close 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.

This inspection took place on 6 January 2016 and was unannounced.

The inspection was carried out by three inspectors, two experts by experience (ExE)and a specialist advisor in dementia care. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke with local authority safeguarding and contracts teams.

During the inspection we spoke with 24 people who used the service and nine relatives. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider, the non clinical manager, two clinical managers, four nurses, 2 activity coordinators, one care coordinator, ten care workers, the chef and a housekeeper.

We looked at 15 people's care records, people's medicine administration records, five staff records and other records relating to the management of the service.

Following the inspection we gained feedback from three health and social care professionals.

Good

Is the service safe?

Our findings

At our last inspection on 14 May 2015 we found that medicines were not being managed safely. Following our inspection the provider sent us an action plan telling us how they were going to improve the service. At this inspection we found that improvements had been made. Medicines were managed safely and people received their medicines as prescribed. Most medicines were administered from a monitored dosage system (MDS). Regular audits of all medicines were completed weekly. Medicines were stored safely. Temperatures were measured and recorded daily for the medicine's refrigerators and the rooms where medicines were stored. Records showed temperatures were within required limits. The medicine trolley was secured in a locked room when not in use and the nurse responsible for the medicine administration held the keys. People received their medicines as prescribed. Where people were prescribed PRN (as required) medicines the nurse asked people if they required them. For example, one person was prescribed PRN pain relief. The nurse asked the person if they had any pain and administered the pain relief medicine when the person confirmed they were in pain.

We saw thickener (used to thicken fluids for people with swallowing difficulties) was not always stored safely. One person had a container of thickener on a table in their room. We spoke to the nurse on the unit who was not aware of the patient safety alert issued by NHS England regarding the safe storage of thickener. The nurse immediately removed the thickener and took action to ensure it was stored safely. We spoke to the clinical manager for the unit who was aware of the patient safety alert and assured us action would be taken to ensure thickener was stored safely.

People told us the service was safe. One person said, "I feel very safe and well cared for here". Relatives and visitors were sure people were safe. Comments included: "The place feels very safe I don't have any worries when I leave him, reassuring" and "We see a beautifully run home. Nothing to show that anything is not safe". One relative told us they were confident that people were now safe because when an incident had occurred there had been an apology and steps taken to avoid further incidents.

Staff we spoke with were knowledgeable about their responsibilities to identify and report concerns relating to safeguarding vulnerable people from abuse. Staff knew where to report concerns outside of the organisation if needed. This included reporting to the local authority safeguarding team and the Care Quality Commission (CQC). Information about how and where to report concerns relating to safeguarding were displayed through the service. Records relating to safeguarding showed the service had carried out thorough investigations and taken appropriate action where safeguarding concerns had been raised.

People told us there were enough staff to meet their needs. Comments included; "There are plenty of staff and I always get my medicine at the same time, I never wait for anything. We have a laugh in here" and "Lots of staff about. When you need someone they come quickly".

Staff told us staffing numbers were sufficient to meet people's needs and that there was good team working. However, staff were concerned about the impact on people of the high use of agency staff. One member of staff said, "Agency staff can make it difficult because they don't know what to do". This was supported by

our observations throughout the day. We saw staff guiding and prompting agency staff to ensure people's needs were met. For example, one person was asking to use the toilet. An agency member of staff did not respond to the person's request. A permanent member of the staff team prompted the agency staff to respond to the person's request.

We spoke to the provider and the two clinical managers about the number of agency staff on duty. The provider told us about recruitment strategies that had been put in place to improve recruitment and we saw that several new staff had been interviewed and offered posts. The clinical manager for Dorchester and Clifton units told us they had worked with staff to make changes to the rota to ensure agency staff were always supported by experienced members of staff. We looked at rotas for a four week period which showed that at least 50% of permanent staff were on duty to support agency staff.

People's care plans contained risk assessments which included risks associated with nutrition, moving and handling, continence, pain and behaviour. Where risks were identified plans were in place to identify how risk should be managed. For example, one person's care plan identified a risk of bruising when moving and handling. The care plan detailed how the person should be moved to reduce the risk of bruising. Staff we spoke with were aware of the person's moving and handling needs.

Records relating to recruitment of new staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

People's safety was maintained through the maintenance and monitoring of systems and equipment. We saw that equipment checks, water testing, fire equipment testing, hoist/lift servicing, electrical and gas certification was monitored by the maintenance staff and where required was carried out by certified external contractors. We saw equipment was in service date and clearly labelled.

Good

Is the service effective?

Our findings

At our inspection on 14 May 2015 we found the provider was not adhering to the principles of the Mental Capacity Act 2005 (MCA). 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. At this inspection we found improvements had been made.

Staff had received training in MCA and understood how to support people within the principles of the Act. Staff were able to describe how they would support someone who may lack capacity to make specific decisions and how decisions may need to be made in a person's best interest.

Care records contained mental capacity assessments to determine if people had capacity to make specific decisions. Where people were assessed as lacking capacity there were records relating to decisions made in a person's best interest. Where people needed specific support to maximise their capacity this was documented in the person's care plan. For example, the care plan for one person living with dementia contained a capacity assessment identifying the person had capacity to make decisions about daily living. The care plan further identified staff needed to 'spend extra time with [person] to ensure he understands the question'.

Where people were assessed as being deprived of their liberty this was being done in their best interests and was legally authorised under the MCA. Applications had been made to the supervisory body in line with the Deprivation of Liberty Safeguards (DoLS). DoLS allow people who are assessed as lacking capacity to be deprived of their liberty to receive care and treatment when this is in their best interests.

Permanent staff employed by the service had the skills and knowledge to meet people's needs. One person told us, "I've no complaints, staff know me and seem well trained. They take good care of me". Agency staff were supported by permanent members of staff. One agency care worker told us, "I work with permanent staff and not alone". This ensured agency staff were supported to enable them to meet people's needs. Health professionals told us nursing and care staff were knowledgeable about people's needs.

Staff told us they had received training which included; safeguarding, MCA, dementia, first aid and moving and handling. One new member of staff had completed their induction. The induction had included training and a period of two weeks shadowing a more experienced member of staff until they felt confident to work alone. Nurses had received training to ensure their clinical skills were kept up to date. Staff told us they were able to request training that would enable them to provide quality care for people. For example, one member of staff told us they were attending training in end of life care.

People benefited from staff who were supported by an effective supervision and appraisal system. The proprietor had reviewed and introduced a new supervision process that gave staff control of their supervision. Staff were encouraged to identify areas for their own development and to lead supervision

discussions to enable them to identify ways to address issues. Staff were positive about the supervision process. Staff told us they felt supported by the new management team. One member of staff said, "I have had face to face training. I have regular appraisals and supervision. I can't fault this home".

People were extremely positive about the food. Comments included: "The food is delicious"; "There is plenty to eat and drink in here, have you seen the menu board? They put up pictures of what we are going to have on that" and "The food is excellent". One person who was on a weight reducing diet told us, "The food is very good, salads and low calorie meals. I am losing weight".

People were able to choose from the menu which was clearly displayed in each unit. Staff supported people to understand the menu choices and showed pictures to help them choose. If people did not like the menu choices the chef would prepare something they preferred. Food looked appetising, including pureed food which was shaped in moulds to resemble the solid form of the food.

People chose where they wanted to eat their meals. There were dining rooms on three of the units and a communal 'bistro' on the ground floor of the home. Several people were eating in the bistro, some people were sat at individual tables in quiet corners on the units and other people were eating in their room. Meals were enjoyed in a sociable and cheerful atmosphere throughout the home. Staff were encouraged to have meals and a drink with people where it helped people living with dementia to mirror the actions of eating. This increased people's food intake.

Care plans detailed people's dietary requirements. For example, people who required pureed food, fortified meals or had food allergies. We saw people received food to meet their needs and staff were aware of people's nutritional needs. The chef had a clear knowledge of people's nutritional needs and there was a system in place to ensure the chef was made aware of people's changing needs or the needs of people as soon as they moved to the home.

Where people were at risk of weight loss this was identified and food and fluid intake monitored. The management team had developed a system to track nutritional trends. A recent analysis of the information had identified people who were supported to eat and drink were at higher risk of weight loss. As a result action had been taken to ensure staff had sufficient time to spend with people. We saw that people who chose to have their meals in their room were encouraged and supported by staff who had time to sit with them. As a result of the increased support people were gaining weight.

People were supported to maintain good health. People were referred to health professionals appropriately and records showed people had accessed G.P, care home support service (CHSS), speech and language therapist (SALT), mental health team, physiotherapy and occupational therapy. Where people had accessed services this was recorded in their care files. Health professionals told us people were referred to them appropriately and in a timely manner.

The environment on the unit specialising in care for people living with dementia enabled people to walk about freely. The area was brightly coloured with pictorial signs to support people to find their way around the unit. Outside people's individual rooms there were memory boxes containing pictures and items to prompt recognition. Doors were painted in bright colours and resembled an external front door. Around the corridors were items for people to stop and engage with, for example a wooden board with keys and locks.

Good

Is the service caring?

Our findings

People benefitted from caring relationships with the staff. People were positive about the caring nature of staff supporting them. Comments included: "The carers are very caring and well managed"; "So far I am favourably impressed. I think they [staff] are excellent, all of them"; "I'm getting very good care"; "The staff are lovely, they look after me well" and "The staff are kind to me and very caring" Relatives also told us staff were caring. One relative told us, "Staff are kind and friendly". Another relative said, "I am very happy, the care is excellent".

One health professional who visited the home regularly told us "The atmosphere is friendly and caring".

Staff enjoyed working in the home and had a caring approach to their work. One member of staff told us, "I feel the care here is good. I like to get to know the residents and have a chat with them". One nurse said, "You need to be kind. You need to explain what you are going to do".

There was a caring culture in the home. We observed many kind and caring interactions throughout the day which included the whole staff team. Care staff used their knowledge of people to support them in a compassionate way with patience and understanding. For example, one person was walking along the corridor and became anxious. A member of the care team immediately approached the person held her hand and started talking to them about their family. This reassured the person and they relaxed.

We saw a member of the catering team greeting a person. The member of staff gently touched the person's arm and said, "It's lovely to see you. It makes my day when I see you smile". The person clearly enjoyed this interaction and smiled long after the member of staff had left the room.

The maintenance person chatted to people in the corridor as they passed. One person was clearly concerned about an issue and the maintenance person took time to reassure them and passed the information to a care worker.

The management team took time to stop and speak with people. The interactions were positive and people laughed and chatted with them. It was clear people saw them regularly and were comfortable to speak with them.

People were treated with dignity and respect. People were addressed by their preferred name. When people required support with personal care this was done in a discreet, respectful manner. For example, one person became agitated, staff identified the person needed the toilet. The member of staff spoke quietly to the person, offering to support them. The person responded by smiling and walking with the member of staff.

Staff were respectful to each other and when staff were speaking to each other about people this was done in a respectful manner.

Staff took time to reassure people and ensure they were involved in choices and decisions about their care,

making sure staff understood what people really wanted. For example, one person was offered a drink. The care worker asked if the person would like their drink to be 'hot or cold', when the person decided they would prefer a cold drink the care worker then took time to ensure the person understood the different choices and then confirmed the choice when the person had decided.

Relatives told us they were involved in people's care. One relative said, "We have regular meetings about [person] care and we are kept fully informed if anything is changing".

The home supported people to remain in the home at the end of their life, if this was their choice. Advanced care plans had been completed with people and their relatives and identified how people wished to be cared for. The advanced care plans were based on the Gold Standards Framework (GSF). The GSF is a framework to ensure better lives for people and recognised standards of care when people are approaching the end of their life. One person's care plan stated, 'to be cared for in a clean environment, comfortable and pain free as possible'. There was a pain management plan in place with regular referrals to the GP to review the effectiveness of the pain relief. Advanced care plans were reviewed monthly or more regularly if needed and updated.

Requires Improvement

Is the service responsive?

Our findings

People's care records were not always accurately completed and up to date. One person's care record contained a photograph of a pressure sore identified on 25 December 2015. There was no further record of any action taken as a result of identifying the pressure sore. We spoke to the agency nurse on the unit who was not aware the person had a pressure sore. The nurse checked the care plan and found no record of any action taken. The nurse told us they would take immediate action to ensure the person's pressure sore was appropriately treated. We told the clinical manager for the unit who advised they would ensure the nurse had taken appropriate action. Following the inspection we spoke with the clinical manager for the unit who confirmed the pressure sore had healed. The manager told us issues had been addressed with the member of staff who had failed to act in line with policies and procedures relating to recording of wound care.

Another person's care summary stated 'compliant with medicines' there was no record on the summary that the person received their medicines through a percutaneous endoscopic gastrostomy (PEG). The person's summary also stated 'on healthy diet', there was no record on the summary that the person required pureed diet and thickened fluid.

We found that documents were not always completed. For example, one person's well-being care plan had not been completed and the risk assessment regarding pressure care was not fully completed.

There were summaries of people's care needs on each unit in files called 'at a glance'. This enabled staff to have an overview of people's care needs. These were detailed and identified how people wished to be cared for. However, these were not completed for people being admitted to the home in intermediate care beds. Intermediate care beds were used for people who no longer required acute hospital care, but who needed interim care whilst long term discharge plans were made. For one person we found the 'at a glance' information for the room number referred to someone who had previously occupied the room. This put people at risk of receiving inappropriate care. We spoke to the provider and unit manager about this who told us these would be immediately updated.

This issue is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People enjoyed living at The Close and were able to access activities that interested them. Comments included: "Oh yes its good here"; "We have been to couple of lunches and festivals. Very good" and "I always enjoy exercise, always do a lot".

The home employed two life skills support workers (LSSW). LSSW's were responsible for organising activities to meet people's social needs. The LSSW's were enthusiastic about their role and knowledgeable about people's histories, likes and dislikes. Activities were tailored to meet people's individual needs. For example, one person enjoyed typing. The provider had purchased an adapted keyboard and the person was being supported to write a blog for the home's website. The person told us, "I started on the computer last week and I am writing the homes blog".

During the inspection we saw people engaged in a variety of activities. A seated exercise to music session took place. People responded positively and were happy and motivated to take part. There was a creative arts session in the bistro and a pantomime was planned for the evening of our visit.

Throughout the day people enjoyed social interaction in the bistro; we saw people supported by staff and relatives to visit the bistro for lunch, tea and coffee. There was a cheerful atmosphere; management and staff stopped to chat with people and their relatives. One person was doing a jigsaw puzzle, staff stopped to help and spent time chatting. The person obviously enjoyed the activity and the social interactions, laughing and joking with people as they stopped.

People living with dementia were supported to spend time engaging in activities they enjoyed. For example, one person was settled and calm while nursing a doll. A member of staff supporting the person told us the doll had been specially purchased as it was more realistic in its weight and appearance.

People who chose to remain in their rooms received one to one visits which included nail treatments, pamper sessions, quizzes and visits from pet therapy. The provider brought their dog to the home, which was popular with some people living in the home. One person told us how much they enjoyed the dog visiting and liked to have the dog spend time lying on his bed.

People's care plans contained information relating to their life histories, likes and dislikes. For example one person's care plan stated the person liked classical music, when we visited them in their room classical music was playing. Another person was a supporter of a football club; their room was decorated with football memorabilia.

Care plans were written in a respectful manner and identified how people wished to be supported to meet their needs. Where people required regular monitoring records showed checks were taking place. For example, where people required repositioning to reduce risk of pressure care there were records showing this was taking place.
However, one person who had recently been admitted to the home in an intermediate care bed required a daily clinical observation to be carried out in order monitor their condition. This had been identified during the assessment of the person prior to them moving into the home. However this was not documented in the person's care plan. We spoke to the nurse who told us the observation had been taken on the day the person moved into the home but the nurse was not aware that it should be carried out daily. We spoke to the clinical manager for the unit who told us they would address this immediately.

People knew how to make a complaint and felt confident to do so. Comments included; "I have never complained I could if I wanted to. I would tell the staff" and "I have never complained there is nothing to complain about. I suppose I would tell the staff". One person told us they had made a complaint and the matter had been resolved to their satisfaction. Another person had complained about their call bell not being answered. They had received an apology and it had not happened again. One member of the care team told us the provider "won't rest" until an issue raised by a person or a relative had been resolved.

There were copies of the homes complaints policy displayed throughout the home. We saw records of complaints received. All complaints had been investigated and responded to in line with the organisations complaints policy.

Good

Is the service well-led?

Our findings

Since our last inspection the provider had introduced three new house managers to the service. One non-clinical manager who was responsible for all areas of the service not related to care provision and two clinical house managers; one responsible for Riverview and Willow units and one for Dorchester and Clifton units. At the time of our inspection the clinical manager for Dorchester and Clifton units had submitted an application to CQC to become a registered manager for the service. The clinical manager for Riverview and Willow was in the process of submitting their registration application to CQC. The provider aimed to have two clinical lead nurses to support the two managers. One clinical lead nurse had been appointed and a second clinical lead post was vacant.

The management team promoted a caring, open culture. The atmosphere throughout the day was calm and friendly. People were happy to speak with the management team, who knew people and their relatives well. Staff were relaxed and spoke with ease to the proprietor and home managers.

People and their relatives were positive about the new management team. Comments included: "The atmosphere is much better"; "The managers are lovely, nice relaxed people. You feel you can talk to them"; " We have always been made to feel welcome"; "[provider] is brilliant, he turns up at any time and checks on things"; "I am very happy, care is excellent and the new manager is very good" and "It's getting good; the two managers have made a difference, both very good and approachable. The staff seem more relaxed now and [provider] is very good and always listens".

Health and social care professionals were complimentary about the changes made in the home and the new management structure. One health professional said, "It really has transformed over the last few months. The one thing that has really improved; there is leadership of the care staff. The senior carers are very knowledgeable". Health professionals supporting people being admitted to the intermediate care beds were positive about the clinical home managers. Feedback from one health professional stated, 'They [clinical managers] have been very careful about how they have planned their admissions into the 11 beds we have commissioned there to make sure that it doesn't impact on the care of their existing clients. They have been very engaged in the whole process, contacting us with any issues that have arisen so they can be dealt with swiftly'.

People were able to attend meetings to enable them to feedback about the service and to keep them informed of changes. No one we spoke with had attended the meetings. We saw minutes of meetings which identified who had attended and what had been discussed. Minutes of a recent meeting showed that the clinical home managers had been introduced and people had been informed of the change in the management structure of the home. There were weekly managers 'surgeries' advertised throughout the home to encourage people and staff to talk to managers about any concerns or ideas they may have. The clinical managers told us no-one had attended but felt this was due to people and relatives being able to talk to managers at any time.

Staff felt supported by the new management team. Comments included; "The managers and proprietor

have been very supportive of me"; "They [management team] are happy to listen to us" and "Things are much better now". We saw that some staff who had left the service had recently returned to work at the home.

Staff were positive about the new supervision process that had been introduced which enabled staff to lead their supervision. The provider told us the aim was to encourage staff to be proactive in recognising their own development needs and identifying solutions to any issues.

There were regular staff meetings for staff at all levels. Records of meetings showed staff were encouraged to make suggestions to improve the quality of care. Staffing was discussed and ideas to improve recruitment had been discussed. A bonus scheme had been introduced for any staff introducing a new member of staff to the home. Records showed that staff were thanked for their work and praised when quality of care had improved. For example, the response times for call bells had been a concern. This had now been addressed and staffed were thanked for their commitment to improvement. During our inspection call bells were answered in a timely manner.

Meetings held between heads of departments identified areas of improvement around the governance of the service to enable the service to continuously learn and improve. One of the clinical managers told us the service was introducing a governance group to enable improvements in learning. For example, the service recorded and investigated all accidents and incident, however it was not always clear what action had been taken to reduce the risk of a reoccurrence. The governance group would look for trends and patterns.

The provider and wider management team were clearly passionate about providing high quality care in the home. The proprietor had employed an independent consultancy company to carry out an in depth audit of the service. The audit had identified the issues we found during the inspection. The proprietor and managers were working with the consultancy company to develop an action plan to address the issues and to improve the quality of care. The audit included; health and safety, infection control, safeguarding, consent, dignity, user involvement, nutrition and catering and medicines management.

The provider had other improvements in progress; an electronic care plan system was being introduced, a new broadband service was being installed into the home to facilitate internet access for people using the service. The provider had purchased electronic tablets for the LSSW's to enable them to support people to keep in contact with relatives and friends.

Activities were being organised to improve links with the local community. For example, the provider had spoken to representatives from the local community to offer the grounds at The Close for the village summer fete. People from the local community were invited to coffee mornings and events organised at the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that records were accurate, up to date and complete. Regulation 17 (1), (2)(c)