OSJCT

Watersmead

Inspection report

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Ratings

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

Overall summary

Watersmead is a residential care home providing accommodation for up to 50 people, some of whom may have a dementia. At the time of our visit there were 47 people living at the home. Watersmead is a purpose built property on one level.

The service had a registered manager who was responsible for the day to day operation of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was present on the day of the inspection.

People and their families praised the staff and registered manager at Watersmead for their kindness. People had developed caring relationships with staff and were treated with dignity and respect.

Staff worked closely with health and social care professionals for guidance and support around people's care needs. People's care needs had been assessed and

Summary of findings

reviewed on a monthly basis. Care records were not completed to a consistent standard. Some records lacked sufficient detail or it was unclear which information was current.

Staff were not confident in their understanding of how the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards should be applied in their roles. Assessments of capacity and best interest decisions were not always recorded when people lacked capacity to decide on their place of residence, care or treatment.

Staff had received training in how to recognise and report abuse. There was an open and transparent culture in the home and all staff were clear about how to report any concerns they had. Staff were confident that the registered manager would respond appropriately. People we spoke with knew how to make a complaint if they were not satisfied with the service they received.

There were systems in place to ensure that staff received appropriate support, guidance and training through supervision and an annual appraisal. Staff received training which was considered mandatory by the provider and in addition, more specific training based upon people's needs such as, dementia awareness.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were systems in place to ensure there was sufficient staffing at all times. New staff were employed following a robust recruitment process which ensured they were safe to work with people before they began their employment.

Staff were confident in recognising safeguarding concerns and potential abuse and were aware of their responsibilities in protecting people.

There were systems in place to ensure that people received their medicines safely. The environment was safe and well maintained and the equipment which people used was maintained and fit for purpose.

Is the service effective?

Requires Improvement

The service was not fully effective. There was a lack of understanding around the use of the Mental Capacity Act 2005 code of practice in terms of due process and quality of recording. The provider did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of the people in relation to the care and treatment provided to them.

People were supported to have enough to eat and drink. Where required, people had access to specialist diets.

Staff received regular supervision and an annual appraisal which identified ongoing training needs and development.

Is the service caring?

Good

The service was caring. We saw that people were comfortable in the presence of staff and had developed caring relationships. People and relatives were very positive about the staff and said they were treated with kindness and respect.

Staff knew people well and were aware of people's preferences for the way their care should be delivered, their likes and dislikes. Staff listened to people and acted upon their wishes. Staff supported people to make their own decisions about their day to day life.

Is the service responsive?

Requires Improvement

The service was not fully responsive. The standard of recording within the care records was not consistent and some information was ambiguous.

People and relatives said they were able to speak with staff or the manager if they had a complaint. They were confident their concerns would be listened to.

Staff ensured that people were not socially isolated. There were opportunities for people to take part in social activities, if people did not wish to participate, staff would sit and chat to people in their rooms.

Summary of findings

Is the service well-led?

Good

This service was well led. People and their families told us they thought the service was well led. There was an open and transparent culture and the manager and staff welcomed the views of people who lived at Watersmead.

There were systems in place to monitor the quality of the service provided and to promote best practice.

Watersmead

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 over two days on the 3rd and 4th February 2015 and was unannounced. This inspection was carried out by a team of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. 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 plan to make. This enabled us to ensure we were addressing potential areas of concern.

We spoke with 17 of the 47 people living at Watersmead. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to assist us to understand the experiences of the people who could not talk with us. We spent time observing people in the communal areas.

During our inspection we spoke with three visitors, a visiting GP, the registered manager, a regional manager, a care leader, the acting activities co-ordinator, a housekeeper, chef and seven care workers. Following our visit, we contacted people who visit the home to find out what they thought about this service. We contacted three health and social care professionals.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of ten people, looked at four staff training records, staff handover documents, cleaning schedules, medicine administration records, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

Good

Is the service safe?

Our findings

People told us they felt safe living in Watersmead. One person said "I am alright here, staff comfort me when I am worried". Another person told us "Yes, I feel safe living here, nothing at all to worry about".

Visitors and people alike said they had never heard a raised voice from staff or witnessed anything that had made them feel uncomfortable. One person said "This home is not like the ones you read about in the papers; please make sure you write that in your report". Another person said "This is a good place; you will never find another one as good as this in England".

People living at Watersmead were safe because the service had arrangements in place to ensure people were protected from abuse and avoidable harm. The risk of abuse to people was minimised because the policies and procedures in place were followed by staff.

There was a safeguarding and whistleblowing policy and procedures in place which provided guidance on the agencies to report concerns to. Staff had received training in safeguarding to protect people from abuse and training records confirmed this. Staff were able to describe what may constitute as abuse and the signs to look out for. A member of staff told us "I would pass on any concerns to the manager who would make a referral to the safeguarding team if needed". Another care worker told us "I would report concerns to my team leader and would be prepared to go higher".

There were effective recruitment procedures in place which ensured people were supported by appropriately experienced and suitable staff. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

There were adequate staffing levels in place to support people who live in Watersmead. We saw that staff were visible and available to people. The manager told us that as new people moved into the home they would review the staffing numbers based upon the needs of new residents.

People had risk assessments which identified risks in relation to their health and wellbeing, such as moving and handling, mobility, nutrition and hydration and social isolation. Risk assessments were updated each month or sooner if required and staff told us they were confident the risk assessments kept people safe while enabling them to make choices and maintain their independence. Dedicated members of staff had a list of people who lived in the home and carried out an hourly check to ensure that people were safe. Each person had to be seen and accounted for and staff checked that people who remained in their room had a call bell to hand should they wish to call for a member of staff.

People using the service could be confident that their medicines were organised and administered in a safe, competent manner. People received their medicine on time and staff were knowledgeable about the type of medicines which people took and why they were prescribed.

Medicines were stored in the medicines room in a lockable cabinet which only certain members of staff had access to. Records showed that stock levels were accurate and balanced with the number of medicines which had been dispensed. There were protocols in place for the administration of medicines that were prescribed on an 'as and when needed basis' (PRN medicines). Senior staff had responsibility for administering and disposing of medicines and undertook training and competence checks to ensure they remained competent to deal with medicines.

Safeguarding records evidenced that the registered manager took appropriate action in reporting concerns to the local safeguarding authority and acted upon recommendations made. Notifications were made to the Care Quality Commission (CQC) as required. There was a low level of incidents or accidents occurring within the home and the records showed that following incidents or accidents, risk assessments were updated or put into place.

The provider had risk assessments in place for the environment and facilities, such as ensuring that the water systems were regularly checked for legionella. [Legionella is a disease which is caused by bacteria in water systems]. Fire equipment was regularly tested and there were personal evacuation plans in place for people in the event of a fire. Should the premises need to be vacated in an

Good

Is the service safe?

emergency, alternative accommodation and transport had been arranged for people. There was also a contingency plan in place should staffing levels be affected by sickness or adverse weather conditions.

The home was well maintained and safe throughout. The layout of the building promoted people's independence, dignity and safety. The communal areas of the home were clutter free, spacious and accessible for wheelchair users.

We saw people moving around freely, either independently or in their wheelchair. The level of cleanliness and hygiene throughout the home was of a very high standard. This included people's rooms and all communal areas.

A variety of equipment was used by people to support their independence, maintain good health and ensure that staff could support them safely. Before using the equipment, care workers ensured that it was safe and fit to use. There were audits in place to evidence that faults were reported and checks were carried out for correct usage and wear and tear.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

The Deprivation of Liberty Safeguards is part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make a certain decision and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

The registered manager told us that staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of their safeguarding training. However, we found that this training was not fully effective as the registered manager and staff were not confident in their understanding of how the MCA and DoLS should be applied in their roles. There was a similar understanding about the lawful use of restraint.

The registered manager confirmed that these were areas where further training was needed. The head of care confirmed that assessments of capacity and best interest decisions were not always recorded when people lacked capacity to decide on their place of residence, care or treatment and that there was some confusion about how to use the MCA in practice.

During the inspection, the registered manager told us they were in the process of making applications for DoLS authorisations. Following the inspection, the registered manager notified us to inform us that this has now been completed and submitted to the relevant authority.

We looked at ten care records and found records of assessments of capacity and best interest decisions were not in place for some people that lacked capacity to decide on their care and treatment. Those assessments that were in place, did not meet the requirements of the MCA Code of Practice in terms of due process and the quality of recording.

In one person's records, an assessment of capacity and best interest decision was in place regarding 'sometimes resisting having personal care'. However, the best interest decision did not define how the personal care should be provided in the person's best interest. In another person's records we saw that a best interest decision was unnecessarily taken and recorded because the person had capacity to make the decision about assistive technology being installed. Following a risk assessment, a discussion with the person around the need for the equipment and their consent, would have been all that was required to ensure the equipment was installed lawfully.

One person had been prescribed a pain relieving patch by their GP. The documentation referred to a best interest decision being made to prescribe the patch and the GP had been consulted and involved in the decision making process. However, there was no documentation which demonstrated the registered manager had undertaken an assessment of capacity and best interest for the administration of the medication. During the inspection we spoke with the care lead around the role of the GP to prescribe and the home to administer medicines. Documentation relating to capacity assessments and best interest decision should relate only to specific responsibilities of the GP and the home.

The provider had produced their own best interest form, however completed forms lacked sufficient detail and information. This meant that evidence for the conclusions on which decisions would be made was not always recorded. There was missing evidence which included; how the best interest decision was the least restrictive of the person's rights, how the person's wishes and feelings had been taken into account and how the views of relevant others had been taken into account.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulations 2010. This corresponds to regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were positive when describing the care and support people received. Health and social care professionals spoke positively about the care and support stating that staff were skilled and caring in their approach.

Care records evidenced that health and social care professionals, such as the mental health team, speech and

Requires Improvement

Is the service effective?

language therapy and podiatry services were involved in people's care. People were referred to professionals by the staff to assess and review their health needs. Staff told us they provided specific guidance to support the effective delivery of care. We observed one carer who deflected one person's interest away from what was making them agitated, this quickly calmed the person. The information about how to support this person in particular situations was given in the person's care records.

We looked at ten care plans. Where appropriate, we saw that guidance was available to staff and other professionals on how to most effectively communicate with the person to enable them to express their wishes. Such as, making sure people had their hearing aids on and were working properly, being aware that some people would lip read so to be sure to face the person, repeating back what the person had asked for, rephrasing the question or allowing more time. Some people had assistive technology such as a different tone on their room telephone or a vibrating bleep on their mobile telephone.

The design and layout of the building promoted people's independence and privacy. The home was purpose built on one level and the building was fully wheelchair accessible. Communal areas were bright and hallways were wide and straight which meant that people could walk unsupervised without the risk of knocking themselves on protruding walls. There was a circular route through the home so those people who wished to spend their time walking could do so safely.

There were hand rails on both sides of the walls throughout all of the communal areas. In addition, bathroom and toilets had grab rails for support. There were colour changes on the walls between the different areas of the home and picture signs on doors and wall for easy recognition. Staff said they 'fully respected people's privacy if they wished to stay in their room with their door closed'.

Most people were very complimentary about the food. Comments included, "Friday is best – fish and chips" and "Wonderful food, it is all very good and there is a good choice", "I enjoy my food, it is a good standard, normal food well cooked, especially desserts". One visitor told us "When my relative was admitted they were malnourished, but now they eat everything and have put on weight".

The dining room was attractively set out and a picture menu was available for people to look at. During lunch the staff showed people different plates of served food so that they could make their choice visually. Food was nutritious and presented well. People said they had plenty to eat and we saw that snacks and drinks were offered throughout the day. Staff sensitively supported people to eat and drink as required.

Care plans documented people's likes and dislikes together with any food allergies or intolerances. We saw that specialised diets were catered for such as, pureed, gluten free, bite size food or vegetarian. People's food and fluid intake was monitored by staff where a risk of dehydration or malnutrition had been identified.

Training was available to ensure that staff had the necessary skills and knowledge to be able to support people appropriately and safely. Staff told us they received the mandatory training required by the company, such as safeguarding, infection control, manual handling and health and safety. Training records confirmed this and also provided a list of forthcoming training. Staff undertook training specific to the needs of the people they cared for, such as dementia awareness and diabetes.

Individual meetings were held between staff and their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. During these meetings guidance was provided by the line manager in regard to work practices and opportunity was given to discuss any difficulties or concerns staff had. Annual appraisals were carried out to review and reflect on the previous year and discuss the future development of staff.

New staff undertook a six month probationary period in which they completed an induction. The induction included looking at care plans, completing the mandatory training, familiarising themselves with the services policies and procedures and shadowing more experienced staff members.

Good

Is the service caring?

Our findings

There were many positive comments from people and their relatives when we asked about the caring approach of staff. One person said "I couldn't praise the service enough, you've got your independence, they don't interfere and I consider it like a five star hotel". Another person said "It's marvellous here, you couldn't wish for a better place".

Comments from visitors included "My relative is very happy here, they are treated with respect and humour, staff are getting to know what they like and are creating a book about their life history" and "I am really happy with the care here, they are all lovely caring people, they have empathy with older people and react to their needs, they know the way my relatives likes everything done".

Positive relationships had formed between people and staff. There were open signs of affection and terms of endearment being used appropriately. People appeared comfortable and relaxed in the presence of staff. Staff spoke with people in a warm and caring manner, listening to and responding to their requests in a timely and considerate way.

We saw many examples where staff treated people with respect and dignity and people told us they felt valued and respected. A care worker said "We respect people for who they are. We don't discriminate, everyone is different, and that's what makes this job worth doing". We observed that staff asked permission from people before they carried out tasks, such as before moving the person in their wheelchair. Care staff ensured people's privacy by knocking on people's doors and waiting before entering. And, staff ensured that people received personal care in the privacy of their own room.

During the lunch time, we observed one practice which could be seen as compromising people's dignity due to a lack of privacy. Most people had their medicines given to them whilst they were sat in the dining room with other people. Staff told us that people had the choice where they took their medicine.

We asked 12 people if they were happy with this practice. Everyone told us they were. In addition, three people took their medicines in the privacy of their own room by choice. We discussed this practice with the manager who told us they had consulted with people previously and the outcome was that people were happy with this. However, they had already considered that this practice was not conducive to a person centred approach to care. They had looked at resourcing additional mobile medicine cabinets to enable people to receive medicine in the privacy of their own room.

Staff demonstrated an understanding of people and their emotional needs and how they could best support them. During our visit, one person became distressed and was wandering through the hallways of the home. The manager and care staff dealt with the situation in a sensitive way by ensuring the person had privacy away from other people. They supported the person with compassion and kindness, offering reassurance which greatly calmed the person.

Care staff were able to tell us about the people they cared for. Their culture, life history, what work they used to do, what was important to people now and what they liked or disliked. People's care records reflected what staff had told us. Minutes of the staff meetings demonstrated the service promoted a person centred and respectful approach to people who live at Watersmead.

The records evidenced that attention to detail in respect of people's wishes was important in the provision of care. People were consulted about the running of the home and encouraged to put forward new ideas, such as 'having afternoon tea at the table'. Staff members were encouraged to actively engage people in conversation and to support people to participate in activities.

Information was available to people and their families regarding health matters and advocacy services. The manager told us they had supported people to access advocacy services to enable them to voice their opinion and make their own decisions, such as in dealing with financial matters or through an independent mental capacity assessor. [Advocacy is a process of supporting and enabling people to express their views and concerns and access information and services through an impartial service which is independent of family or the service]

Requires Improvement

Is the service responsive?

Our findings

We observed that people looked well cared for and staff demonstrated a sound knowledge of their care needs. However, the care records did not accurately reflect the care being provided or required. We looked at ten care records and found that the quality of recording was inconsistent. Some sections lacked sufficient detail, had incorrect information or did not give adequate explanation. This may impact on the safe delivery of care and the health and well-being of people.

Within four care records, information given in the person's monthly review of care was different to that of their care plan. For example, two people were assessed as needing two carers to assist with personal care yet the care plan stated they required one carer. Another person required one person to assist them to go to the toilet, yet the monthly review of their care plan stated they were independent and did not require support. One person's monthly review said they were not on a specialised diet yet their care plan stated they were. The records had either not been updated to reflect the changes or cross referenced to changes brought about through a review of their care and support.

People's care plans were reviewed on a monthly basis or more often if their care needs changed. However, the content was often repetitive and did not always reflect the changes which had occurred. This meant that staff did not have access to up to date information which may result in the person not receiving the care they require to keep them safe and well.

Care staff completed a daily record of the care people received and details about how people had spent their day. Of the ten records we looked at, only two daily records made a clear and descriptive reference to the emotional well-being of the person and the actions they had taken. Daily recording described behaviours as 'wandering', 'anxious', 'unsettled', 'happy', 'depressed', 'appears to be in good spirits'. There was no description of what this meant for the person. A lack of recording which describes behaviours or actions taken may prevent staff sharing important information and assist in ensuring that timely and appropriate support was planned and given.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 Good Governance (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a warm, caring and welcoming atmosphere at Watersmead. People appeared to be contented and well cared for. The dining room and lounge areas were a hub of social interaction, people chatting, laughing and listening to music, visitors coming and going, people going out or taking a stroll around the hallways. During our visit we saw that people spent time reading the newspapers, going out in the garden, playing board games and relaxing in the lounge. People told us they went out for lunch, visited family or places such as the garden centre. For people who did not wish to join in with activities, the acting activities co-ordinator spent one to one time with them, either doing an activity, chatting or just reminiscing; this reduced the risk of social isolation.

The registered manager was in the process of recruiting an activities co-ordinator as the previous person had retired. A member of the care staff was temporarily organising activities. Information about activities was displayed on noticeboards throughout the home. Families and other visitors were welcomed to the home and there were no visiting restrictions.

Before people moved into the home, the management team undertook a pre-admission assessment to ensure the home could offer the appropriate support the person required. Care records contained a pre-admission assessment which was completed during a visit to the person by one of the management team. This included reviewing the person's health, emotional and social needs to assess if the home could meet their needs.

Each person had a care plan in place which detailed what support the person required in relation to their health, mobility, social and personal care needs. Care records documented people's preferences in relation to their care and daily living. Families were involved if people could not fully express their preferences. Staff told us that the information given in the care plans enabled them to deliver care in the way the person wanted. We observed many interactions between people and staff which evidenced that staff were knowledgeable about the person's wishes.

Requires Improvement

Is the service responsive?

People's individuality and characters were acknowledged by staff who knew the likes, dislikes and eccentricities of people very well. We observed staff nodded and said hello to one person who was taking their daily stroll around the home in their hat and coat. Another person had put their 'dressing gown' on before lunch and then chose a chair in the foyer where they wanted to eat their lunch. Their wishes were fully respected and accepted.

People's preferences were supported by staff. People went into the dining room at different times throughout the morning and staff offered various breakfast options. People's rooms were individualised; they commented on how they were encouraged to bring in photographs, ornaments and small items of furniture and memorabilia from home and were able to arrange the room as they wanted.

People received support from health and social care professionals such as the mental health team, speech and language and for dental and optical care. We saw evidence in the care records that referrals had been made to professionals when staff had identified a need. For example, one person was seen by the speech and language therapist due to swallowing difficulties. Care staff liaised with the chef to ensure that food was prepared in a way to minimise the risk of choking.

Information about the complaints policy was displayed in the foyer and available within the information leaflet about the home. No complaints had been received in the last year and seven low level comments had been put forward through the suggestion cards. The registered manager took the comments seriously and sought to provide resolutions, including giving apologies in some cases. The responses evidenced a respectful and problem solving attitude from the registered manager.

Resident meetings were in held and recorded. The minutes of the meetings evidenced that people were consulted about some decisions regarding the running of the home. The regional manager recognised that some people may not wish to speak at meetings. To overcome this, they offered face to face meetings with people to gain their feedback and opinions.

Good

Is the service well-led?

Our findings

The service had a registered manager in place and there were clear lines of accountability from registered manager to staff. Staff were able to tell us about their roles and responsibilities. There were regular staff meetings, which reinforced the values of the service and how staff were expected to work. Staff and the registered manager told us they felt the home met the ethos and vision of the Orders of Saint John Care Trust. This was to provide 'high quality individualised care for people".

All of the staff were positive about the provider and the management team. They were complimentary about the registered manager, their style and felt well supported. One member of staff said "Such good management, they are staff orientated, take immediate action. A top rate manager, has a heart of gold and loves the residents". Visitors to the home commented "They [the care team] have created a home from home with positive caring staff where residents are happy".

Staff told us and minutes of staff meetings evidenced that the home had an open and transparent culture. We observed that staff approached the registered manager as they needed to. Staff commented there was an open door policy and they could raise any concerns they may have with the management team. A care worker said "The standard here is high; they [the manager] will have a word with staff if they see something they shouldn't be doing. Everyone works well as a team". Another member of staff told us "The home is well led, if there is a problem, it gets sorted. We have the resources and training to do our job well".

The registered manager told us that staff were highly valued throughout the organisation and staff told us they felt valued. Within the team meeting records we saw that staff were regularly thanked for their contribution. A national staff award was held annually whereby staff were recognised for their achievements.

The provider had a system in place to monitor the quality of the service. This included monthly and quarterly audits completed by the registered manager and monthly checks by the regional manager. In addition, the quality of service delivery was monitored by a clinical governance lead and the quality team.

The audits covered areas such as health and safety, staff training, supervision and appraisals, care plans, management of medicines, incidents and reporting on levels of falls. The audits highlighted areas for improvement and development.

People who live at Watersmead, their family and other visitors to the home were able to express their views in person to the registered manager or staff. In addition, people had the opportunity to give feedback about the way the service is led through their six monthly review. The Orders of Saint John Care Trust employ the services of an independent consultancy firm called MORI firm to illicit the views of people and their family. This information is collated centrally to inform service development, improvements and future planning within each of the homes.

The service worked in partnership with key organisations to support the provision of joined up care. Care planning documents evidenced that referrals were made by the service for the involvement of various health and social care agencies.

The registered manager was proactive in working with local initiatives and the community, such as the Care Partnership, Skills for Care, community centres, schools, hospices and provider forums. Staff training and development was promoted through access to organisations such as, NAPA [National Association for Providers of Activities for Older People] and the Alzheimer's Society. Best practice guidance was accessed through various websites such as, the National Institute for Clinical Excellence, Social Care Institute for Excellence, NHS Choices and the Care Quality Commission.

Best practice was shared and promoted and monitored through regional and home manager meetings, a national staff newsletter, staff meetings and within staff training.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records This corresponds to regulation 17 Good Governance (1) (2) (c) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were not protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Care records lacked detail and were ambiguous.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment This corresponds to regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of understanding around the use of the Mental Capacity Act 2005 code of practice in terms of due process and quality of recording. The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of the people in relation to the care and treatment provided to them.