St Anne's Community Services

# St Anne's Community Services - Heatherstones

## 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? | Outstanding |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 4 August 2016 and was unannounced.

The last inspection was in January 2014 and at that time the provider was meeting all the regulations inspected.

St Anne's Heatherstones is a purpose built home consisting of two interconnected bungalows. Each one had four bedrooms, a kitchen, lounge and communal bathroom. There is a conservatory which serves as the manager's office and there is an enclosed garden which is accessible to people living in the home. The home provides personal and nursing care to adults with learning disabilities. At the time of the inspection there were eight people living in the home.

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

People told us the service was safe. We found staff knew how to recognise and report any concerns about people's safety and welfare. The provider had updated the policies and procedures around protecting people from abuse and staff had received training to make sure they understood their responsibilities. The provider followed safe recruitment processes and all the required checks were done before new staff started work.

Staff were trained and supported which helped to make sure they had the right knowledge and skills to meet people's needs. There were enough staff to provide people with the support they needed and to make sure they had plenty of opportunities to take part in social and leisure activities.

Overall people's medicines were managed safely. However, there were some concerns around the lack of protocols for some 'as required' medicines and the recording of information about medication changes.

People were supported to meet their health care needs and had access to the full range of NHS services. When people had to go into hospital staff at the home worked closely with the hospital to make sure they got the right support. One person who lived at the home had made a film about one aspect of their experience as a patient. With the support of the registered manager they had attended various conferences and events to help raise awareness of the challenges which people with learning disabilities can experience when they need medical treatment.

The home was clean, generally well maintained and well equipped to meet people's needs. This included specialist baths, ceiling track hoists and pressure relieving mattresses. People's bedrooms were furnished and decorated to reflect their tastes and interests.

The service was working in line with the principles of The Mental Capacity Act 2005 and this helped to make sure people's rights were protected and promoted. People were asked for their permission before care and support was provided. When people did not have the capacity decisions the right procedures were followed to show how decisions had been made in their best interests.

People were offered a variety of food and drink and their likes and dislikes were catered for. However, when people's fluid intake was being monitored the recording was not always accurate.

People's needs were assessed and each person had their own care and support plan which included detailed information about their needs, abilities and preferences. The care and support people received was person centred, they were supported to make decisions and be in control of their lives. People were supported to make the most of their abilities and to be as independent as possible. People who lived at the home and their families were involved in planning how their care and support was delivered.

Staff were kind and compassion and treated people with respect and dignity. We observed staff were attentive to people's needs and understood people's individual ways of communicating.

People received excellent end of life care and their families were supported with sensitivity. The service has won awards for the quality of the end life care provided.

People had the opportunity to take part in varied range of social and leisure activities inside and outside the home and people were supported to go on holiday.

There was a complaints procedure in place and information was made available to people in a suitable format. There had not been any complaints since the last inspection.

The registered manager was open, transparent and enthusiastic about their role. They were approachable and supportive and interacted with people in a positive way which provided a good role model for staff.

The home was calm and friendly and people were comfortable with the staff. People who used the service, their families, carers and other stakeholders were given the opportunity to say what they thought about the service and offer suggestions for improvements.

The provider had systems and processes in place to monitor and assess the safety and quality of the services provided. However, we found some improvements were needed in how they were operated to make sure they were consistently effective.

There was one breach of regulation. You can see the action we have asked the provider to take at the back of the full inspection 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?

Good

The service was safe.

People were protected by staff who knew how to recognise and report abuse.

There were enough staff and safe recruitment procedures were in place, which helped to ensure that only staff who were suitable to work with vulnerable adults were employed.

People received their medicines safely but there were some shortfalls in the records.

The home was clean and well equipped to meet people's needs.

### Is the service effective?

Good

The service was effective.

People's rights were protected and promoted and their consent was obtained before care and support was provided.

Staff were trained and supported to develop the skills and knowledge needed to meet people's needs.

People were supported to have a varied and nutritious diet and their preferences were catered for.

### Is the service caring?

Outstanding

The service was extremely caring.

People who lived at the home and their families experienced care that was tailored to their individual needs and was empowering

People were treated with dignity, respect and compassion.

People and their families received excellent end of life care and support.

## Is the service responsive?

Good

The service was responsive.

People's needs were assessed and their support plans provided detailed information about their individual needs, preferences and abilities.

People were supported to live active lives and take part in leisure activities in the home, in the local community and to go on holidays.

Information about the complaints procedure was provided in a suitable format□

## Is the service well-led?

Requires Improvement

The service was not consistently well led.

The home was calm and well organised and had a friendly atmosphere. The registered manager was open and transparent and everyone we spoke with said they were approachable and supportive.

There were arrangements in place to monitor and assess the safety and quality of the services provided. However, improvements were needed to make sure they were consistently effective.

People who lived in the home, their relatives and others involved with the service were given the opportunity to share their views about the quality services provided.

# St Anne's Community Services - Heatherstones

**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 4 August 2016 and was unannounced.

The inspection was carried out by two inspectors. We spoke with seven people who lived at the home, two relatives, two nurses, one student nurse, four support workers, the cleaner and the registered manager. We observed people being supported in the communal rooms.

We looked at two peoples care records which included support plans and risk assessments. We looked at medication records, staff files, training records and other records related to the day to day management of the service such as maintenance reports, meeting notes and surveys. We looked around the home at the communal areas and a selection of people's bedrooms.

Before the inspection we reviewed the information we held about the service. We contacted the local authority and CCG (Clinical Commissioning Group) to seek their views of the service. 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 document was completed and returned to us.

Good

# Is the service safe?

## Our findings

People told us the service was safe. The provider had recently updated their safeguarding policies and procedures. As part of this update staff had been given a pocket sized guide to help make sure they had easy access to information about safeguarding. The staff we spoke with had a good understanding of how to recognise and report concerns about people's safety and welfare. The registered manager was aware of their responsibilities in relation to safeguarding and notified the relevant agencies appropriately. This demonstrated the provider had appropriate arrangements in place to help reduce the likelihood of abuse going unnoticed and help protect people from the risk of abuse.

The service supported some people to manage their personal money. We found there were clear procedures in place for staff to follow to reduce the risk of errors or financial abuse. We saw regular checks were carried out by the registered manager to ensure these processes were being followed. We checked the records and monies held for two people and found they were correct.

We observed medicines being administered by a qualified nurse who demonstrated a good level of awareness of the medicines they were administering. We saw they carefully checked the medicines administration record (MAR) prior to administration to ensure people were receiving the correct medication. We looked at the MARs and saw a photograph of each person was attached to the front sheet. This reduced the risk that medicines might be given to the wrong person.

Some medicines were prescribed with specific instructions about how and when they should be taken in relation to food. We found there were suitable arrangements in place to make sure these instructions were followed.

The MARs we looked at were generally well completed. However, we found no protocols had been completed for some medicines administered on a PRN basis to ensure nursing staff had clear guidance on when these medicines should be administered. This was discussed with the registered manager who confirmed they would address this matter.

Some people who lived at the home were not able to take their medicines by mouth; their medicines were administered through a Percutaneous Endoscopic Gastrostomy tube (PEG). We saw there were clear instructions for staff to follow to make sure people received their medicines safely.

Certain medicines are classified as controlled drugs which means they have to be stored, administered and recorded in a specific way. We looked at the way controlled drugs were stored and administered and no concerns were raised.

The temperatures of the rooms used to store medicines and the medicines fridge were checked daily to make sure medicines were stored correctly. We saw nursing staff carried out daily checks on medicines to ensure the stock control figures were correct and a full medicines audit was undertaken once a month.

The usual staffing levels were one nurse and three support workers during the day and one nurse and one support worker at night. The registered manager was supernumerary and there was a clinical lead nurse whose responsibilities included supporting the staff team to meet the needs of people who used the service. The service employed a cleaner who worked ten hours a week, for the remainder of the week the support workers were responsible for cleaning.

The registered manager told us they monitored the staffing numbers and skill mix and used a dependency tool to help determine the appropriate staffing numbers and skill mix. The dependency tool took account of people's individual needs, the layout of the building and the qualifications and experience of the staff team. In addition to the permanent staff team the service provided work placements for nursing students from Huddersfield University.

The registered manager told us they were in the process of recruiting staff to support worker roles and had just appointed a nurse subject to completion of all the required checks. They told us they tried whenever possible to cover vacancies with their own staff and only used agency staff as a last resort. When agency staff were used they tried to get the same people to ensure continuity of care.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included ensuring a Disclosure and Barring Service (DBS) check was made and two written references were obtained before new employees started work.

We looked around and found the home was clean and generally well maintained. The home was well equipped to meet people's needs, for example there were ceiling track hoists and specialist baths.

Risks to people's safety and welfare were identified in their individual care records and it was evident action was taken to reduce, minimise or manage known risks. For example, many of the people living in the home relied on the track hoists to help them move and the service had a mobile hoist which provided back up if track hoists were not working for whatever reason.

We looked at a selection of maintenance records and they showed the checks on equipment and installations were up to date. This included water, gas, electricity, fire equipment, hoists and slings. A fire risk assessment had been done and the registered manager told us a sprinkler system had been installed last year in response to risks identified by this assessment. There were individual Personal Emergency Evacuation Plans (PEEPs) in place which showed how people who lived at the home should be supported in the event of an emergency. The service carried out two fire drills a year which helped to make sure staff were familiar with what to do in the event of a fire or emergency evacuation. In addition, the provider had an advice line which provided out of hours management support for staff in the event of an emergency.

The provider had a system in place to make sure alerts about medical equipment and/or medicines were cascaded to the home and where necessary action was taken to deal with the risk. The registered manager told us the provider was moving to an electronic system which would make this easier to manage and monitor.

Accidents and incidents were monitored and analysed to look for trends and patterns. This information was used to help reduce the risk of the same thing happening again. The incident/accident forms were checked and signed off by the area manager every month. This was to make sure any actions needed following accidents and/or incidents had been completed.

We spoke with the cleaner who told us about the cleaning schedules they followed and explained the colour

coded system they used for cleaning cloths, mops etc. We saw cleaning materials were stored securely and there were COSHH (Control of Substances Hazardous to Health) assessments and data sheets available. We observed staff used personal protective equipment (PPE) such as gloves and aprons. The service was inspected in December 2015 by the local authority environmental health department and given a score of 5, the highest, for its standards of food safety and hygiene.

Good

# Is the service effective?

## Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager explained how they assessed the restrictions placed on people who used the service and where they identified these amounted to a deprivation of the person's liberty and the person lacked capacity to consent to their care and treatment, applications were made. We found these applications were appropriate and based on sound knowledge of the correct processes to follow.

The registered manager told us there were six DoLS authorisations in place with another one awaiting authorisation by the supervisory body. We looked at the conditions place on one DoLS and found they had been fully met. The registered manager had a system in place to identify when DoLS authorisations were approaching their expiry date to ensure a further assessment was carried out.

The registered manager demonstrated they had a good understanding of the MCA and how it should be applied in the home. Where people lacked capacity a best interest process was followed.

The staff we spoke with told us they always sought people's consent before assisting them with personal care tasks and reassured them throughout the process. They also told us if people were unable to communicate verbally they looked for other signs they consented such as observing their body language and/or facial expressions.

We observed the lunchtime meals and saw people were given time to eat their meals and there was a relaxed atmosphere. We saw people were assisted or prompted to eat their meals appropriately and staff sat with them and encouraged them to take an adequate diet. The home does not employ a chef and therefore the care staff were responsible for preparing all meals. The care staff we spoke with told us they did the weekly food shop at a local supermarket and were always accompanied by at least one person who lived at the home.

We saw the majority of people had a soft or blended diet and required assistance to eat their meals. It was apparent when speaking with staff that they had a good understating of people's dietary needs and their likes and dislikes. In addition, we saw nutritional guidance for individual people was available to staff. This included information on any swallowing difficulties they may have, if they required blended food and how to

provide a nutritious and balanced diet.

We saw people's weight was monitored and if people experienced any significant weight loss it was discussed with their GP or other healthcare professionals as appropriate

People's care records showed they had access to a range of healthcare professionals which included GPs, dieticians, speech and language therapists and opticians. The registered manager told us staff had good working relationships with other healthcare professionals and always followed their advice and guidance. This was confirmed by a health care professional we contacted before we visited the service. People had Hospital Passports in place so that vital information about their needs was readily available to hospital staff when needed. The registered manager told us they worked closely with the hospital to make sure people got the right support when they were admitted to hospital. For example, in one case funding had been secured so that staff from the home could stay with the person for the duration of their hospital stay.

The staff we spoke with told us the training opportunities were good and provided them with the skills and experience to carry out their roles effectively. They told us the registered manager encouraged them to take up training and was pro-active in finding courses relevant to the needs of the people in their care or for their own personal development. This was supported by the records we looked at.

All new staff had a period of induction training and staff who were new to care work or did not have relevant qualifications were required to complete the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It was designed to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care.

In the staff files we saw new staff were supported during their induction by regular review meetings which monitored their progress. There was a training matrix which provided details of all the training staff were required to undertake and how often it should be updated. This included training on safe working practices such as moving and handling, fire safety, infection control, safeguarding and emergency aid. However, it wasn't clear from the matrix how often nursing staff should have a training update on medicines and we found one of the nurses had not completed medicines training since July 2013. This was discussed with the registered manager who told us all staff involved in the administration of medicines had a competency assessment every two years. However, we did see any documented evidence to support this.

In addition to training on safe working practices, staff received training on topics such as positive behaviour support, epilepsy, catheter care and the MCA and DoLS.

There was a planned programme of staff supervision and appraisal. Appraisals were done annually and staff then had a minimum of five one to one supervisions between appraisals. The registered manager told us nursing staff were supported with the NMC (Nursing and Midwifery Council) revalidation process. This is a process whereby nurses provide evidence to show they are keeping up to date with good practice and is a condition of NMC registration.

Outstanding ☆

# Is the service caring?

## Our findings

Everyone we spoke with was extremely happy with the caring approach and attitude of the staff team who they described as kind and friendly.

One relative we spoke with said "The staff are absolutely brilliant; they treat everyone as individuals and are so kind and caring. When [name of person] was in hospital they only gave them a short time to live and the manager admitted them to Heathertones knowing that. However, since admission they have made a remarkable recovery to the point where they will soon be discharged to another home in the community. I cannot thank the manager and staff at Heatherstones enough for the support they have given not only to [name of person] but also to the rest of my family."

The same relative told us they were able to visit when they wanted to and there had never been any restrictions on visiting. They told us they were always made to feel welcome when they visited the home and offered a drink and light refreshment.

A health care professional told us, "I am confident they [Heatherstones] are delivering a good standard of care. The manager and clinical lead are both working effectively in ensuring that resident's needs are being met. It is a home who has residents with very high needs for support and these are all reflected in their individual support plans, risk assessments and involvement of the residents or relevant individual involved in care"

Not everyone who lived at the home was able to communicate verbally therefore we observed how staff interacted with people throughout the day of inspection.

We saw staff treated people with understanding, kindness, respect and supported people at their own pace. We heard staff clearly explaining and asking permission before they assisted people. The home had two dignity champions and had recently taken part in a dignity audit. The audit findings were being collated by the manager of another St Anne's service and were not yet available.

We saw care records included information about how people could be involved in making decisions about their care and welfare. The relatives we spoke with told us they felt people could make choices and wherever possible staff involved them in the decision making process.

It was evident from speaking with staff and observing their interactions with people that they were aware of people's needs. We found there was a genuine sense of fondness and respect between staff and the people who lived at the home. We saw people laughing and joking with staff. The staff we spoke with told us it was imperative people were happy living at the home and had a good quality of life.

We saw people were confident and relaxed in the presence of staff and staff were able to communicate well with them. For example, where people had limited or no verbal communication they used a variety of different method to understand their needs. These included observing their body language and facial

expressions and using pictorial prompts.

Staff evidently knew people well and had built positive relationships. The relatives we spoke with stated they felt the staff knew people's needs well and were able to respond accordingly. They told us they felt their relative was very happy living at the home and was treated as an individual. We saw people's bedrooms were personalised to reflect their individual tastes and interests.

Staff showed a person centred approach to the people they were supporting. For example, we observed staff discussing with people what they would like to do during the day and what activities they wanted to participate in. One person was asked if they wanted to go out for a walk in the park or stay at home to do activities. Another person was planning to go out later in the week and staff were discussing with them what time they wanted to leave and what they wanted to wear on the trip.

In another example, we observed one of the people who lived in the home sitting in one of the lounges after breakfast. They started to show signs of distress and without any delay a member of staff went and sat beside the person. They held the person's hand and spoke quietly with them and within minutes the person had relaxed and fallen asleep.

We saw people's personal care needs and preferences were clearly recorded in their support plans and wherever possible people were encouraged to maintain some level of independence. For example, two people who lived at the home had been supported to purchase power assisted wheelchairs they could control themselves in order to increase their independence.

One person who lived at the home had limited verbal communication but very good understanding. With the support of the registered manager they sat on the interview panel for student nurses at the University of Huddersfield. The same person had taken part in a joint enterprise with the local NHS Trust and the university. This had involved them making a film about their experiences of having a PEG (Percutaneous Endoscopic Gastrostomy) tube fitted. With the support of the registered manager they had attended various conferences to show the film and share their experiences. This had resulted in the person being jointly nominated for the Nursing Times awards for partnership working in 2016. Although they had not won they had enjoyed attending the awards ceremony. We spoke with the person and it was evident they were proud of their achievements. This demonstrated the service was fully committed to supporting people fulfil their potential.

The home provided excellent end of life care to people. They had achieved Gold Standards Framework accreditation and been acknowledged for their high quality end of life and palliative care, winning the PCPLD (Palliative Care for People with Learning Disabilities) network Linda Mc Enhill Award in 2010 and 2015. This demonstrated a sustained quality of care over a five year period. In 2015 the home achieved a highly commended award in the category of 'Outstanding end of life support of an individual'. The judges commented they were particularly impressed how the service had involved families and supported them with great sensitivity. The registered manager shared an example of how they had supported a family following the death of their loved one.

Good

# Is the service responsive?

## Our findings

The care plans and supporting documentation we looked at was person centred and provided support workers with the information required to provide people with appropriate care, support and treatment. We saw care plans were updated on a monthly basis or sooner if there were significant changes in people's needs. We saw each person living at the home had a named nurse and care staff who took a special interest in their care and support.

We saw the care provided was in line with the care records. For example, when people needed specialist equipment to help them stay safe or be more independent this was provided.

We saw staff responded appropriately if people requested assistance or support. We saw wherever possible people were involved in their care and staff always explained what they wanted to do and asked for people's consent before carrying out care tasks or giving support.

We saw everyone had a leisure dairy in place and a person centred plan which outlined their objectives and which was reviewed on a regular basis. We saw people benefitted from a wide range of activities both within the home and the local community. The home had an adapted lease vehicle which made it easier for people to get out and about. We saw they had regular trips out to places of interest using their own transport and were supported by staff to go on holiday. We saw one person had recently enjoyed a holiday to Blackpool and another person had travelled to Ireland with two staff to spend some time with their family.

Within the home there was a sensory room and the registered manager told us a reflexologist and beautician visited people at home to provide treatments.

The registered manager had established links with a local church and services were held in the home for people who wished to attend.

The staff we spoke with told us it was important to them that people had the opportunity to lead a full and active life within a risk management framework.

There was a complaints procedure in place. Information about the complaints procedure was available in an easy read format. The registered manager told us they had not been any complaints since the last inspection. We saw there had been one small concern raised by a relative and this had been dealt with immediately. The registered manager said they tried to deal with any concerns as they arose and this meant people did not need to make formal complaints. The registered manager also kept a record of compliments. One person was so pleased with the progress their relative had made since moving to Heatherstones they described it as a 'miracle.

Requires Improvement

# Is the service well-led?

## Our findings

The home had a relaxed and organised atmosphere. Staff supported people calmly and confidently and we saw people living in the home were at ease and comfortable in each other's company and with staff. We observed positive interactions between the registered manager, staff and people living in the home.

The staff we spoke with were very complementary about the registered manager and qualified nursing staff. One said "The manager is very approachable and leads by example." Another said "The manager and nurses are very supportive and we all get on well and work as a team which is really important in such a small home."

There were regular staff meetings to help keep staff up to date and give them the opportunity to share ideas and suggestions for improvements. The staff meeting also provided an opportunity for reflection, for example in May the meeting had reflected on the circumstances around the death of person who had lived in the home. The person had passed away in hospital and the meeting provided a forum for staff to talk about what had gone well, what hadn't and what could be improved in similar circumstances in the future.

The service did not have 'house meetings' for people living in the home. People were consulted on an individual bases and had a formal review of their care and support package at least once a year.

The provider sent annual surveys to people's relatives and other stakeholders such as health care professionals. They were usually sent around October and November. In 2015 the provider had only received a small number of responses but they were all positive. People who had completed the surveys were not given any feedback and we discussed this with the registered manager.

The provider had recently introduced a quality and safety audit based on the five CQC domains of safe, effective, caring, responsive and well led. The provider's quality audit team carried out a full audit at Heatherstones in June 2016 and overall the service performed very well. They achieved the highest possible rating in the areas of client activities, support planning and end of life care. The audit identified some improvements were needed; these were mainly in relation to record keeping.

The registered manager told us the actions from the audit had been completed. However, we identified some further concerns in relation to record keeping. When we looked at the daily fluid charts which were used to monitor people's fluid intake we found they were not completed correctly. For example, one person's fluid chart dated 21 July 2016 indicated they had only taken 250mls of fluids and there was no entry on the chart after 12:45pm. On the 22 July 2016 the same persons chart showed they had taken only 350mls of fluid and there was no entry on the chart after 19:00. The fluid chart for the 23 July 2016 showed they had their first drink at 9:00am. This suggested they had not had not drank any fluids for 14 hours. In addition, there was no evidence staff were totalling up the amount of fluids people were taken on a daily basis or that this matter had been identified through the internal audit system. We discussed this with the registered manager and staff on duty and we were assured the person had received sufficient to drink but staff had failed to record this correctly. The registered manager confirmed this matter would be addressed.

Similarly when we looked at how people's medicines were managed we found improvements were needed to the records. For example, we saw some people who had medicines prescribed to be taken 'as and when required' (PRN) were actually having these medicines on a regular basis. The nurse in charge confirmed changes to people's prescribed medicines were always discussed and agreed with their GP. However, they acknowledged they could not always evidence this in the care records and the MARs had not been changed to reflect this. We also found protocols had not always been completed for medicines administered on a PRN basis to ensure nursing staff had clear guidance on when these medicines should be administered. This had not been identified by the monthly medicines audits. We discussed this with the registered manager who confirmed they would address this matter.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The area manager visited the service at least once a month and carried out checks on different aspects of the service. We saw action plans were completed following these visits; however, it wasn't clear how long actions could remain outstanding before they were escalated within the organisation. For example, in May 2016 the registered manager had reported a loose flagstone just inside the entrance gate which presented trip hazard. When we visited the flag stone was still loose and although this had been raised in the monthly meetings the registered manager was not able to tell us when the repair work would be done.

While it was evident the provider had systems and processes in place to monitor and assess the safety and quality of the service we concluded improvements were needed to ensure they were operated effectively.

The provider had a number of external quality awards which included Investors in People – Gold, Mindful Employer and Stonewall Diversity Champions.

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Accurate and complete records were not always maintained in respect of each person who used the service. Regulation 17(2)(c) |