Mr & Mrs G Butcher

Lyndhurst Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 31 May and 1 June 2018 and was unannounced. At the last inspection we found the provider did not operate systems that ensured the quality and safety of the service. At this inspection we found improvements had been made to the quality monitoring systems, however, not all shortfalls had been identified.

Lyndhurst Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lyndhurst Park accommodates 27 people in one adapted building. At the time of our inspection there were 24 people living there with two people admitted during our inspection.

There was a registered manager at the service. 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 who lived at the service and their relatives were complimentary about the care and the staff. They felt staff knew them well and delivered effective and kind care. They told us they were happy living at the home and enjoyed the food. Relatives told us they were confident their loved ones were safe and well cared for. Relatives told us that they felt the service was particularly good at making it feel like home.

We found shortfalls in the management of medicines during our inspection and we identified this was a breach of regulations. The registered manager took steps to address these quickly, however this was a breach of regulations at the time of our visit.

We found some areas within the home needed maintenance. The provider told us they would address these immediately.

The provider's systems had not identified the shortfalls in ordering and storage of medicines.

The home was clean and smelt fresh throughout, however the provider had not identified some infection control risks. We have made a recommendation about this.

The provider had failed to display their most recent rating on their website.

The provider had a consistent staff team with very low turnover. Many of the staff had worked at Lyndhurst Park for many years. This had a mostly positive impact in that it created a stable caring environment. People's choices and preferences were respected, although these had not been entered on the new

electronic records system yet.People received care from staff who knew them well. Staff morale was good, and staff felt supported and worked well as a team. However, the longevity of the provider and staff team meant that shortfalls were not always noticed as everyone was used to the environment and to working in a particular way.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Some environmental risks had not been identified.

Accidents and incidents were recorded and informed learning.

People felt safe at the service.

Is the service effective?

Good

The service was effective.

People had their needs assessed before being admitted to the service.

Staff received training and supervision.

Consent was sought in line with legal guidelines

The service worked well with health professionals.

People had choices of food and drink, however records of this were not always consistent.

Is the service caring?

Good

The service was caring.

People and relatives were complimentary about the service.

Staff treated people with kindness, respect and dignity.

People's care choices were respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff who knew them well.

The service had received good feedback from relatives and professionals.

People received kind compassionate end of their life care and their families were supported.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place had not identified shortfalls in medicines administration.

The provider had failed to display their rating on their web page.

Monitoring systems for people's care were not always operated effectively.

The provider had made improvements since the last inspection.

There was a positive staff culture and staff felt cared for and supported.

Lyndhurst Park Nursing 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 31 May and 1 June 2018 and was unannounced.

The inspection team consisted of an inspector, a pharmacist inspector, a specialist advisor who was a registered nurse, 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 inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us. We checked the information on the provider's website.

We spoke with nine people who used the service, five relatives, six members of staff including the deputy manager, and both directors of the company, one of whom was the registered manager. We looked at 13 electronic care records and spoke with a health professional who was visiting the service. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints."

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

The provider did not always manage medicines safely.
Fridge temperatures had been recorded daily however the minimum and maximum temperature had not been recorded. The records could not give assurance that medicines were being stored at the temperatures recommended by the manufacturers. When we checked the thermometer on the day of inspection, the minimum and maximum temperature was outside the recommended range. This meant, for example, that insulin could have been stored at too low a temperature. Following the inspection, the service told us that advice has been sought from their supplying pharmacy and suitable action taken, the provider also undertook to replace all the insulin they currently held in stock.

Nurses administered medicines and recorded this Medication Administration Records (MARs). We reviewed ten MARs and there were no gaps in the recording however, five people had not been given their medicines as they had been out of stock. One person had not received their eye drops. Staff meeting minutes on 13 February 2018 had identified problems with medicines being out of stock. The minutes of the staff meeting on 2 May 2018 identified action to be taken if medication was out of stock. However, medicines being out of stock remained a problem at our inspection.

Care staff applied creams and other external preparations and recorded this electronically. They were prompted by the electronic system when a cream was prescribed, however we identified one person who had not had two of their prescribed creams entered onto the electronic system. This meant the provider could not be sure they had been applied. We returned the following day and found this person's prescribed cream had still not been entered onto the system so we could still not be sure this had been applied. The provider rectified this during the visit.

We observed medicines administration for eight people. We saw that medicines were given in a caring way but it was not always safe. We saw one person who had their medicine left unattended although this had been marked on the MAR as given. This meant that the provider could not be sure the person always received their medicines as prescribed.

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

We looked at the systems in place to manage medicines. Since the last inspection, the storage of medicines had been moved from a central location to individual lockers in people's rooms. The medicines policy had not been updated to reflect this change. On the medicines trolley we found one box of blood glucose test strips which had expired. We were told these were not in use. They were removed from the stock on the day. We identified a sharps disposal bin that was not access secured was in use and stored in an unsecured area.

There were suitable arrangements for storing and recording medicines that required extra security.

Since the last inspection, additional guidance for medicines prescribed to be taken 'when required' had been introduced, and they explained when medicines could be given. However some lacked detail on when the medicine should be administered. Since the inspection the provider has sent two examples of protocols not mentioned above which have been updated to reflect patient-centred information so that the member of staff administering the medicine knows when it should be given.

The provider had not identified all infection control risks in the environment. Some areas of the building were not as well maintained as others which meant there was a risk of contamination. For example, in one of the bathrooms, a metal floor strip had come away from the floor. There was a potential for injury to people as well as a risk of cross infection because the area could not be properly cleaned after each use. We showed this to the provider who arranged for this to be replaced. We identified other infection control risks in the environment. Although one of the hoists we looked at was clean, another was visibly dirty. When this was pointed out, the equipment was immediately cleaned. We have received photographic evidence from the provider to demonstrate these risks had been rectified.

Staff said they had been trained in infection control. Staff had access to personal protective equipment (PPE) such as gloves and aprons and knew when to use it, although these were stored in communal areas such as corridors. We observed on two separate occasions that staff had disposed of gloves into a general waste bin rather than a clinical waste bin. PPE which has potentially been in contact with body fluids is a potential cross infection risk and should be disposed of safely.

The provider recorded incidents and accidents. Although these had been analysed, the detail had not always been included into the care plans. For example, one person had fallen 11 times since 17/03/2018. The incident analysis included details of other interventions that had been considered, such as a sensor mat, but this was not written in the care plan. In the plan it had been documented that a referral had been made to the falls team, but the only other guidance for staff was to assist the person to stand and to observe when walking. There was no specific falls prevention plan in place. Incidents had been graded as red, amber or green to indicate if further action was needed. This meant it was clearly identified when incidents remained open or had been closed.

Although an infection control lead nurse had been identified, they were new in post. They said that at the time of our inspection, infection control monitoring was "informal." They discussed their plans with us on how they intended to include infection control as part of staff supervisions. They also said a cleaning rota had recently been put in place.

The service was visibly clean throughout with no odour. We observed that bathrooms were cleaned regularly. Staff described how they reduced the risk of infection by using fresh sets of gloves and aprons for each person. There were different coloured aprons for staff to wear serving meals to provide confirmation aprons had been changed. A relative told us, "They wear uniforms all of the time , and they wear aprons and gloves when required ". The service also ensured laundry was separated, with any soiled laundry being placed in red soluble bags and washed separately.

People told us they felt safe at the service. Comments included, ""I am safe here all of the time, they come and check on me at night", and, ""I like it here I am tucked in my bed safe and sound".
Relatives said they were confident their loved ones were safe, ""My [Name] has dementia, she is well looked after here and is kept safe, I never have to worry" and, "No problem here [Name] is safe and sound".

Staff were trained to protect people from harm and abuse. Comments from staff included, "I would report things like bruises to the nurse. I've done it before" and "If I saw a bruise I would always report it." Staff also

knew how to report concerns about poor care. One member of staff said "I would report it and keep going higher if I needed to."

People's care plans contained risk assessments for areas such as falls, malnutrition and skin integrity. When risks were identified, the plans contained guidance for staff on how to reduce these. For example, when staff needed to use equipment to move people safely, this was documented. When people had been assessed as being at risk of developing pressure sores, the plans included details of any pressure relieving equipment that was in use and the frequency people needed to have their positions changed. Records showed that staff checked the settings on air mattresses to ensure they were correct. Position change records showed that in the main, people had their positions changed in accordance with care plan guidance.

The provider employed a sufficient number of staff who had been recruited safely. Staff files showed the provider had carried out checks before employing new members of staff. All contained a Disclosure and Barring number (DBS). This is a check that is made to ensure potential staff are safe to work with vulnerable people. Staff files also contained proof of identity, an application form, a contract, right to work details and references.

Staff gave mixed feedback on staffing levels. One said, "We struggle with four staff. Now we've got new residents, there's five of us, but we don't get time to talk to residents. Once we've finished washing and dressing, it's lunchtime." Another said "A lot of our residents are high dependency. I can't always get to people as quickly as I'd like or as they'd like. But we have got more staff because we've got new residents." However, another member of staff said, "Yes, usually, we have enough." Two members of staff told us they always had time to sit and chat.

The provider had ensured regular maintenance was carried out on equipment used in the home. Records demonstrated regular checks for hoists and slings, the lift, the stairlift and gas and electricity supplies. Regular fire alarm, fire door checks and fire drills were undertaken and any identified shortfalls addressed. A fire risk assessment had been undertaken within the last year. The maintenance person carried out regular checks on water systems to reduce the risk of Legionella and on water temperatures to reduce scalding risk.

Good

Is the service effective?

Our findings

People's needs had been assessed prior to moving to the service. These assessments formed the basis of care plans. Any specialist equipment that was required prior to a person moving to the service was done so; for example, specialist bariatric equipment.

The service had recently implemented an electronic care planning and delivery system. This meant there was real time recording of the support staff provided to people, including delivery of personal care, support with eating and drinking and position changes. The provider was able to use this system to monitor care delivery.

The majority of staff said they were trained to carry out their roles. One member of staff told us about dementia training they had received, however another said, "I do think we need dementia training and some more on infection control." One member of staff said, "There's a matrix in place, so the manager tells us what training or refresher training we need to do." Nursing staff said they had access to specialist training in order to meet their professional registration requirements. Staff had regular individual and team meetings with their line manager to discuss their work, personal development and training. One member of staff said, "I had one [a supervision] recently. That's been a new thing since the last inspection" and "We usually have staff meetings once a month. We're encouraged to speak up and make suggestions." One staff member said "I feel well supported most of the time."

People were mostly supported to have enough to eat and drink. People's nutritional needs were assessed and people's weights were monitored. When people lost weight, support and guidance was sought. Records showed that people had been referred to the GP for advice about nutritional supplements. One person was having supplements but didn't like any of the options available. The registered manager told us they had sourced some alternative flavours for the person to try and we saw these were delivered on the second day of our inspection. People told us, "The food is good and the choice is good, this is something they do particularly well," and, "I have just had my breakfast, I asked for one piece of toast, that's what they gave me". During lunch in the dining room staff offered people alternatives if they did not like the meal they had chosen. Staff spent time encouraging people to eat.

One member of staff told us they always checked for other issues, such as a sore mouth, if people were eating less than usual.

People had access to ongoing healthcare. Records showed people had been reviewed by the GP, SALT, physiotherapist, diabetes nurse specialist and the enablement team.

We looked at wound care plans for two people. The wounds had been documented onto body maps and there was clear guidance for staff on the treatment plan. Photographs of wounds were in place. This meant it was easy for staff to identify any signs of improvement or deterioration.

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. Staff understood the principles of the Mental Capacity Act (MCA) 2005 and were able to describe how it applied to people living at the service. They told us they always assumed capacity and understood that they needed to identify the best time to discuss decisions with people, and the need to have accessible information. Staff understood that people could make potentially unwise decisions or refuse treatment if they had capacity.

Consent to care was in the main, sought in line with legislation and guidance. Mental capacity assessments had been carried out and when people lacked capacity, best interest decisions had been made. These had been documented. When people did have capacity to consent, records showed they had consented to receive their personal care, have bed rails in place and receive their medication for example. One exception to this was for one person who had a sensor mat in place. There was no capacity assessment or consent form in place for the use of this.

Some people were receiving covert medicines (medicines given without the person's knowledge). Records showed that people's mental capacity had been assessed and their best interests had been taken into account.

When people had swallowing difficulties, they had been seen by the speech and language therapist (SALT). Guidance provided by SALT had been implemented into the care plans and records showed this was being followed

Another person had been reviewed by SALT who had recommended the person have thickened fluids. The person had refused to have this and they had capacity to make the decision. However, there was nothing documented to show that staff had discussed the associated risks with the person. We discussed this with the deputy manager during the inspection who said they would document a discussion with the person.

Some people were having their food and fluid intake monitored. Although the new electronic recording system meant it was clear to see how much people had eaten and drunk, it was not always clear how concerns about poor intake were identified or escalated.

Another person was also having their intake monitored. In their care plan it was documented they suffered from urine infections and "needs encouragement to drink more fluids." The fluid charts for this person showed that on 25/05/2018 they had drank only 210 millilitres and their urine output had been only 430 millilitres. Again, there was nothing documented to show this had been noted although nurses were aware of it and were taking action. Although the system allowed staff to enter what portion of a meal people had eaten, it did not appear to allow staff to document when a drink had been offered but refused. We discussed this with the registered manager and the provider during the inspection. They said they would liaise with the system developer to see if this could be addressed.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. People's comments included, "Staff are lovely and kind nothing is too much trouble for them", and "Staff are kind when they come into see me, they smile a lot, I like them." Relatives told us, "My [Name] is looked after by staff who are friendly, caring and kind, and they really know what they are doing", and "The staff are wonderful, so kind and caring towards my [Name] and me."

Relatives told us that the one thing they felt the service did particularly well was to make it feel like home. Comments included, "The management and staff are very good at making people feel at home", and, "It's ot posh, but it is a home from home, that's what they do well here."

We observed positive interactions between staff and people using the service. For example, we saw one member of staff walk past one person's room and then go back in to have a conversation with them. We heard them say, "Good morning [person's name]. How are you doing today?"

On one occasion we were walking with one member of staff, who stopped and said "I just have to go and say hello to [person's name]." They went into the person's bedroom and crouched down to their level to say hello to them and gave them a hug. Another member of staff described how they had learnt to communicate with a person with communication difficulties.

Staff spoke very warmly about people and were able to explain how they supported people's preferences. During lunch we saw staff offer several different choices to one person who had not eaten his lunch. Another person needed to be fed by a member of staff and this was carried out in a relaxed way with mutual laughter.

Staff were able to describe people's needs and how they preferred their care. They told us they had time to spend with people. One member of staff told us, "They are all individuals" and "The care is delivered around the individual, they are all different".

Staff spoke positively about their roles. Comments included, "The staff here are very, very caring" and "This is a really nice, easy going place to work. The staff are lovely and really do care."

Staff we spoke with knew how to respect people's privacy and dignity. One said, "I always close curtains and doors, and never leave people exposed during personal care." Another member of staff said, "I always ask people what they want me to do. Maintaining dignity is about never patronising the residents. They're people, not children."

We observed one person being admitted to the service. Staff ensured everybody's bedroom door was closed to protect this person's dignity whilst they were assisted to their room. The following day we saw the registered manager making the person welcome in the dining room, spending time with them and making sure they were comfortable. Another person was admitted during our inspection and we heard staff

speaking of the person's care needs. They also discussed the families needs and demonstrated compassion and concern in these discussions.

People's families were always welcome at the service and were involved in decisions about care. One relative told us, "My sister attends the reviews of the care plan, I look after the money side of things we have Power of Attorney, the care provided here meets all of my [Name] needs all of the time, we would not let her stay here if it did not."

Throughout our inspection we observed visitors to the home were welcomed and had friendly relationships with all the staff.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We were told, "The staff will always come to me if I call them, they sit and talk to me as well", and, "Everything seems to take a long time and the staff are so busy, but they always come to me when I call them." However, another person told us, "Staff keep me waiting sometimes for attention."

Staff supported people to take part in activities they enjoyed. One person had been on several holidays abroad. This year they had decided not to go abroad but to have a hot air balloon trip instead. Both the person and staff were excited about this and looking forward to it.

Some people would have liked more to do. One person told us, "It can get boring here, not a lot to do sometimes", and "I never get to go out of here, it is boring". However another person said, "I stay in my room most of the time, I am never bored here, they (the staff) pop in and out, I watch TV and read". Relatives told us, "My [Name] gets bored here, there are activities, but my [Name] does not always join in", and, "Activities happen in the afternoon, my [Name] joins in if they want to." The provider informed us, following the inspection, that there was a program of activities available at the service. However, we did not see any organised activities taking place over the two days of our inspection.

The service had recently implemented an electronic care planning system. Some staff had been trained in its use, but not all were fully familiar with it. Basic information about people's support needs had been entered, but people's preferences and choices had not yet been documented. However, staff knew people well and were able to tell us about their preferences. For example, people's choices about how they liked to receive personal care, what they liked to wear and whether gentlemen preferred a wet or dry shave had not been documented. The system was still being implemented and whilst basic information had been entered all information had still not been entered. However, staff had access to people's person-centred paper records which detailed their care preferences

People's life histories had not always been recorded in the new system. After the inspection the provider informed us that these were still being transferred from the paper records. Although one member of staff said one person did not wish to share this information, their refusal had not been documented. However, when we spoke with staff about the care and support they provided to people, it was clear they knew about people's preferences. Staff we spoke with were able to describe in detail how they supported people on a day to day basis.

Plans in relation to people's health needs were detailed. For example, we looked at the plan for one person with unstable diabetes. There was a clear protocol in place for staff to follow. Although the signs and symptoms of hypo and hyperglycaemia had not been documented, care staff we spoke with knew the signs to look for. The staff also knew to report any symptoms to the nurse in charge.

Plans for people living with dementia did not always provide enough detail for staff to learn how the dementia affected people on a day to day basis. For example, in one person's plan it was documented

"Behaviour can be challenging" but there was no detail of what this meant. In another person's plan it was documented they could "become distressed and frustrated".. In one of the plans we looked at staff had identified what could trigger the person's aggressive behaviour, but this was only seen in one of three dementia plans we looked at. Despite this the plans did inform staff how to manage people who displayed behaviour that could be challenging.

Staff described how they responded to behaviour which challenged. They said, "We retreat and return", and told us they would continue to do this until they were able to deliver care. One member of staff described how they were taking time to get to know one person's needs and identifying when and when not to interact. They had identified times at which the person did not like to be approached.

Some people had sensory impairments. In these instances the plans were very detailed and guided staff how to support people. For example, guidance we looked at included detail about additional support a person might need at mealtimes because of poor eyesight. The plan also guided staff to "make sure she doesn't feel hurried and is given time to adjust to her new surroundings."

Staff described additional tools they may use to help people communicate. They told us one person had used a computer while with another they would sometimes write things down. Staff were also aware of the use of pictures to help people understand and told us the registered manager was currently trying to get a computer communication system for one person living at the service.

Staff understood what "person centred" meant in their roles. Comments included, "It's care centred around them. We must always offer choice" and, "It's about treating people like human beings and finding out about them." Staff said they learnt about people and their needs from speaking to other staff and speaking to people using the service and their families. One member of staff said, "I sometimes read the care plans." Another member of staff said, "I think we [care staff] have access to the plans, but I've never read them."

People told us they knew how to complain. Comments included, "I know how to raise a complaint but I have never felt the need to", and, "The complaints policy is on the wall, I know how to use it, but I am sure I will never need to." We saw that one complaint had been made to the service and this had been investigated by the provider.

The provider had received a range of compliments from families and health professionals. One health professional we spoke with was very positive about the service, explaining the staff had expected them and were fully prepared for their visit. They told us they were impressed with the service. Another health professional had contacted the service to comment positively on the support provided to people with eating.

Staff described how they delivered end of life care, for example they said, "We give all dignity and respect, still chat away to people, make sure we give mouth care and its important to look after family members". Several members of staff told us about one person who had been supported at the service. It was evident from the way staff spoke that they had all cared for the person and had supported their family. One relative had sent a card which said, "You made her final days very comforting, not just for [Name] but me also.

Although end of life plans were in place, these lacked detail and did not include people's choices or special wishes about how they were cared for at this point in their lives. For example, in one plan there was reference made to a funeral plan and hospice input, but nothing else. In another person's plan it was documented "need to discuss with daughter end of life funeral plans." There was no other detail recorded. The deputy manager said, "We've got good links with the local hospice. We need to improve the end of life

planning, but it takes time to do this in a sensitive way."

Plans we looked at had been reviewed monthly by staff. Although there was an electronic entry that confirmed people using the service had consented to the review, there was nothing documented to show that people's advocates had been invited to take part in reviews, however, relatives confirmed they were involved.

Requires Improvement

Is the service well-led?

Our findings

The provider's systems to monitor quality and effectiveness had not identified shortfalls in the storage and ordering of medicines which was a breach of regulation. Following the inspection the provider sent evidence they had addressed the shortfalls.

The provider had failed to display their rating from the last inspection on their website. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the service and their relatives told us they knew the management team at the service. One person said, ""That's the boss" (The manager had walked into the lounge)". Relatives told us, "The manager is [Name] they are very approachable and open, you can have a laugh with them, the office door is always open", another relative told us, "The manager is open and transparent, you can speak to them at any time either on the phone, face to face when you visit and even email."

The provider and staff demonstrated a consistent attitude and view of the ethos of the service and explained it was to deliver high quality person centred care. Staff told us they felt that this was delivered.

Staff told us that morale was good and were complimentary about the registered manager. One said, "I feel well supported by everyone. I would go to the manager if I needed to." Another said, "When the manager and the provider were away on holiday, they Skyped in daily to check everything was ok." However, one member of staff said, "I think I feel valued and supported in my job; although we don't always get a thank you for extra shifts." The majority of staff who worked at the service had been there many years. We were told, "It is quite a relaxed company to work for, we all get on". Another member of staff said, "Retention is good because it's a lovely place to work, staff and residents – everything".

The provider had introduced a new electronic records system to address shortfalls identified during the last inspection. The system was still being implemented which meant that shortfalls and improvements were being identified. The provider was now able to monitor the care people received as staff confirmed all care delivered on the system. We noted that people's preferences had not yet been entered but the provider told us this was a work in process.

The provider could now identify when people had not received their care, however, we found one person who had not had their skin cream entered on the system.

One member of staff had completed a creams audit, which resulted in them throwing away out of date creams and lotions.

The provider held regular staff meetings. Staff told us it was very easy to raise issues. The registered manager told us that if there were difficulties they would hold an informal staff meeting as soon as possible to discuss things. However, actions identified at staff meetings were not always actioned, as evidenced by the continued failure to have people's prescribed medicines available at all times.

People and their relatives had the opportunity to complete an annual survey about their experiences and opinions of the service. Their most recent survey had been carried out in April 2018. Responses were very positive. In addition the provider encouraged people's relatives to complete the carehomes.com survey and had been in the top 20 for three consecutive years.

The provider employed a maintenance person who was responsible for overseeing repairs around the building. There were no formal environmental checks or infection control audits. This meant some issues we identified had not been picked up by the provider.

We recommend the provider carry out regular infection control and environmental audits.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always available when people needed them. The provider could not be sure medicines were stored at the correct temperature.