Lister House Limited

Sherrington House Nursing Home

Inspection report

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Date of inspection visit: 7 and 8 September 2015
Date of publication: 02/11/2015

Ratings

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

Overall summary

Sherrington House Nursing Home provides accommodation and nursing care for up to 39 people accommodated over three floors. This includes care of people with learning disabilities or physical health needs.

This was an unannounced inspection which took place on 7 and 8 September 2015. On the date of the inspection there were 39 people living in the home. As part of this inspection we checked whether action had been taken to address breaches in regulation we identified during the last inspection on 20 January 2015.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 they felt safe and secure in the home and did not raise any concerns over their safety. Staff understood how to identify and act on any concerns.

Following the previous inspection in January 2015, we found improvements had not been made to the way medicines were managed. People did not always receive their medicines when they needed them and in a safe way.

Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

At the last inspection in January 2015, we found staffing levels were not consistently maintained to ensure safe care. At this inspection we found a greater level of consistency with regards to staffing levels. Although we found staffing levels were safe, staff were busy and did not always have sufficient time to meet people's social needs.

Following the last inspection, improvements had been made to the training management system. Staff received a range of suitable training in ensure they had the correct skills and knowledge for their role.

People reported the food in the home was good and said there was sufficient choice. We found people were provided with sufficiently quantities of suitably nutritious food and appropriate hydration. Nutritional risks to people were well managed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The home's environment focussed on ensuring the least restrictive options, for example in free movement around and outside the home. The manager had made a number of DoLS applications and was awaiting feedback from the supervisory body.

We observed care and found people were treated with dignity and respect by staff. People told us that staff were always kind and treated them well.

A system was in place to ensure people knew how to complain and ensure any complaints were dealt with appropriately.

The home utilised an electronic care record system. However there was a lack of evidence that people had received care and support for example pressure relief in line with the requirements of their care plans.

Since the last inspection in January 2015, the manager had made improvements to the quality assurance system and robust checks in areas such as nutrition, weight management and pressure relieving mattresses were carried out. However improvements were needed to some audit systems, such as care plans and medication checks to ensure they were sufficiently robust to pro-actively identify and rectify risks.

Systems were in place to seek people's feedback on the quality of the service and involve them in decisions relating to the running of the service.

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

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?

Requires improvement 

The service was not always safe.

People were not protected against the risks associated with the use and management of medicines. People did not always receive their medicines and creams when they needed them or in a safe way.

We found staffing levels to be sufficient to ensure safe care. However staff were busy and often did not have time for meaningful interaction with people who used the service.

People told us they felt safe in the home. Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

Is the service effective?

Requires improvement 

The service was not always effective. People spoke positively about the food provided by the home. A varied menu was in place which included sufficient choice. Nutritional risks were well managed and people's weights regularly monitored.

Care records required further information on people's capacity to make decisions for themselves and evidence that the best interest process had been followed in line with the Mental Capacity Act.

People said staff had the correct skills to care for them. Staff received a range of training and had a good knowledge of the subjects we asked them about.

Is the service caring?

Good 

The service was caring. People said they were treated with dignity and respect by staff. We observed interactions within the home and saw staff were kind and considerate. They demonstrated they knew people well and their individual preferences.

We saw people's choices were respected with regards to their daily lives such as where they wanted to sit or what they wanted to eat.

Is the service responsive?

Requires improvement 

The service was not always responsive. Care records did not consistently provide evidence that people were receiving pressure area care in line with the requirements of their care plan.

A programme of activities took place within the home and we saw these were well attended. Some people complained of being bored at times and we saw there was often a lack of interaction from staff in between planned activities and events.

Summary of findings

A system was in place to manage complaints. We found this was appropriately managed and lessons learnt put in place where appropriate

Is the service well-led?

Requires improvement

The service was not consistently well led.

Since the last inspection a number of improvements had been made such as to staff training and monitoring of nutrition and mattresses to ensure they were on the correct setting. However. there remained breaches of regulation which should have been addressed through a robust system of quality assurance with regards to care records and medication.

Systems were in place to seek people's feedback through reviews, meetings and quality questionnaires.

Sherrington House 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 improvements had been made following breach of regulations associated with the Health and Social Care Act 2008 identified during the January 2015 inspection. As this was a comprehensive inspection, we also looked at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 and 8 September 2015 and was unannounced. The inspection team consisted of three inspectors, a pharmacy inspector 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, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. As some people who used the service were unable to speak with us in detail about the quality of the service, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine people who used the service, one relative, six care workers, two registered nurses, the laundry assistant, the cook, the registered manager and nominated individual. We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to our inspections we did not 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. We reviewed all information we held about the provider.

Requires improvement

Is the service safe?

Our findings

At the last inspection in January 2015 we identified concerns relating to the medicine management system. At this inspection we found risks associated with unsafe management of medication remained.

We looked at the medicines, medication administration records (MARs) and other records for six people living in the home. We spoke with the manager and the nurse on duty about the safe management of medicines, including creams and nutritional supplements within the home.

The medicines trolley was not large enough to store all the medicines needed and some boxed medicines were kept on an open shelf below the lockable section. This meant that these products were not secure when the trolley was in use. We saw vaccines and equipment used for taking blood that were out of date and unfit for use. We also saw that insulin in current use was not labelled or dated meaning that it was impossible to see who it had been prescribed for or if it was still fit for use.

Records of creams and other topical medicines were unclear and incomplete. We looked at the records for seven different prescribed creams, but were unable to determine whether or not they had been used correctly. Some prescribed medicines needed to be taken at specific times, e.g. before food to work effectively, but records did not show these had been given at the correct time. The nurse on duty told us that although some medicines were given before breakfast, there were no special arrangements in place for other medicines to be given before food. We checked a sample of medicines against the corresponding records and found five examples where medicines had been signed for, but not actually given and a further five cases where medicines were missing and could not be accounted for. In three cases, records of stock were so inaccurate that it was impossible to determine whether or not the medicines had been administered correctly. Failing to administer medicines correctly and keep accurate records places the health and wellbeing of people living in the home at risk of harm.

We saw that nurses supported people living in the home to take their medicines in a variety of ways. Some people were prescribed medicines that only needed to be taken 'when required', but there was not always enough information available to tell nurses exactly how and when these medicines should be given. It is important that this information is always available so that new or temporary staff, who may be less familiar with the people living in the home, are able to administer each person's medicines consistently and correctly.

Some people regularly spent periods away from the home, ranging from a few hours to several days at a time. We were told that people were given their medicines to take with them, however there were no records of what medicines people had been supplied with and we saw evidence on two people's records that they had not been given their medicines whilst they had been away.

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

People all told us they felt safe in the home. For example one person told us "I feel very safe here, I do." We saw a safeguarding and whistleblowing policy was in place and staff had received safeguarding of vulnerable adults training. Staff we spoke with confirmed they had attended this training and were able to describe how they would identify and act on allegations of abuse, providing us with assurance the training was effective. Where safeguarding incidents occurred investigations took place to help keep people safe. Following incidents, we saw in some cases appropriate liaison had taken place with the local authority, however we identified an incident which although had been investigated, had not been referred to the local authority. We reminded the provider of its need to consistently follow correct safeguarding procedures.

At the last inspection in January 2015 we identified concerns relating to staffing levels. We had concluded that staffing levels were usually adequate but there were inconsistencies in staffing numbers provided from day to day. At this inspection, we found improvements had been made. Rotas' and staff allocation sheets showed consistency with regards to staffing levels. Staff confirmed that staffing levels were consistently maintained, for example that two nurses were always on duty during the day. The manager said that recruitment of nurses had been a challenge. Although use of agency nurses was currently high, a number of new nurses were awaiting a start date. The service ensured that one out of the two nurses on duty was always permanent to reduce the impact of unfamiliar staff on people.

Requires improvement

Is the service safe?

We concluded there were sufficient staff to keep people safe, however staff were rushed at particular times of the day and did not always have time to provide people with meaningful interaction particularly in-between planned activities We received mixed feedback about whether staffing levels were sufficient from people. For example one person told us “At night time, if you ring your bell, they don’t come straight away. They take their time, but they do come” whereas another person said staffing levels were good and “They look after me alright, I like them”. Staff told us that although they were often rushed, staffing levels were not unsafe but they would like a bit more time to spend with people. Some people received 1-1 care and we saw arrangements were in place to provide this. Following the last inspection, a dependency tool had been introduced to calculate the required staffing levels which showed staffing levels were in line with what was required. This assessed people’s dependency with regards to daily living in order to ensure that sufficient staff were deployed to meet their needs. We found the dependency assessments we looked at to be an accurate reflection of people’s needs.

People had a range of risk assessments in place such as for bed rails, nutrition, falls and skin integrity. Generally these were well completed. Where specific risks were identified plans of care were put in place to provide staff with information on how to control the risks. However a number of risk assessments were overdue their monthly review which meant there was a risk they did not reflect people’s current needs.

We looked at incident records and did not identify any concerning trends or re-occurrence of incidents. Following incidents appropriate action had been taken to investigate and keep people safe. For example we looked at one person’s records and saw they had suffered a number of falls earlier in the year but following care plan review there had been a marked reduction in incidents over more recent months. In another person’s records we saw following a number of falls, bed rails had been introduced with the person’s consent. We spoke to the person who told us they were happy with the bed rails and they made them feel safe now. We saw risk assessments were understood by staff, for example we observed the correct number of staff supporting people with mobility and night checks carried out at the required frequency.

Safe recruitment practices were in place. We spoke with a number of new staff who confirmed the relevant checks had been undertaken. This included the completion of an application form, supplying references and undertaking a Disclosure and Baring Service (DBS) check. We reviewed staff files and found evidence the required checks had been carried out.

We undertook a tour of the premises. Bedrooms, including furniture, bedding and carpets were clean and tidy. Although the home was mostly pleasant smelling we did notify a persistent odour on the 1st floor corridor which we brought to the attention of the manager. Daily and weekly cleaning schedules were in place and we saw evidence these were worked to. The building had adequate communal areas for people to spend time, which included a large lounge/dining room and several smaller lounges. The home was adequately maintained. Maintenance staff were employed and systems were in place to communicate and rectify building defects. Regular checks were carried out on the gas, electrical, water and fire systems to help keep people safe. The home routinely kept the entrance door locked from the outside with entry into the home only accessible via alerting staff. We saw that all other points of potential entry were secure. This demonstrated the provider was mindful of the need to provide a secure and safe environment in which to care for vulnerable people.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We found the home's environment focused on ensuring the least restrictive options were used. For example there were no keypads around the building restricting access around the building or outside. We saw people were encouraged and supported to leave the building on their own or with staff to access the local community. The manager had made DoLS notifications concerning two people who lived at the home and was awaiting assessment from the supervisory body.

Staff told us some people within the home did not have capacity to make decisions for themselves. However many care plans lacked information on capacity, the capacity sections were routinely blank which made it difficult to establish whether the correct processes had been followed in line with the Mental Capacity Act. In two people's records, we saw care plans had stated that the person's relative had been asked for consent rather than them being consulted as part of a best interest process. This demonstrated the service did not have a full knowledge of the application of the Mental Capacity Act (MCA). During the inspection the manager took action to address this, refining the way that the information was recorded on the electronic care record system.

All the people we spoke with said they liked the food. For example one person said "The food is smashing. I had porridge and toast and marmalade for breakfast. And two cups of tea. You get tea till it's coming out of your ears." Another said "I've just finished a full cooked breakfast. I give it the thumbs up." Another said "The food's good and I get plenty." We saw a varied range of food was available for people. Trollies went around regularly with snacks and drinks throughout the day. There was a pleasant atmosphere at lunchtime and food looked well-presented and appetising. People were encouraged to finish their meals and desserts were offered. Information was present on people's food preferences on a dedicated sheet available to kitchen staff to ensure that people's individual nutritional needs were met. This included information on any special diets such as diabetic or those with cultural requirements. Pictorial menus were in place to bring the menu to the attention of the people who used the service. The catering staff we spoke with had a good understanding of people's individual needs and said there was a sufficient budget to provide high quality food.

We found nutritional risks to be well managed. People had nutritional care plans in place and their weights were regularly monitored. Where weight loss was identified or people were of low body weight we saw appropriate plans of care were in place and additional control measures such as supplement's or fortification were put in place to help people maintain a healthy weight. People's nutritional risk was regularly monitored by the manager using the computerised care record system.

Food and fluid intake was now documented on the computerised care record system and regularly reviewed by the manager. Regular audits of fluid intake were undertaken by the manager, and where concerns over intake were identified, this was appropriately investigated to determine whether this was a result of poor documentation or lack of intake.

At the last inspection in January 2015 we found staff had not received first aid training. At this inspection we found a number of staff had now received this training to ensure that there was always someone available to assist in an emergency medication situation. People we spoke with all said they liked staff and they were competent in their role. Staff received induction training which included completion of the Care Certificate. They also received a local induction to the ways of working within the home and shadowed for a period of time to get to know the needs of the people they were caring for. This provided us with assurance that appropriate induction training was provided. Staff received a range of training in subjects such as manual handling, safeguarding (including mental capacity) and dementia. Staff we spoke with told us training was up-to-date and had been effective in giving them the skills they needed for the role. Records we looked at showed that most staff training was up-to-date. Staff also demonstrated a good knowledge of the subjects we asked them about. Specialist training in areas such as pressure area and epilepsy was also provided to staff. However we found there was no local induction for agency staff to give them the knowledge they needed for the role. This meant there was a risk they would not know the correct local procedures to follow.

Requires improvement

Is the service effective?

We saw evidence that people had access to external health professionals including chiropody, GP's, and specialist nurses. People told us if they needed a GP or other health professional, then a visit would be organised. We saw care plans were in place which considered people's healthcare needs. However some people in the home had complex medication conditions, but there was a lack of information in place within care records detailing how staff should help manage these conditions. We also looked at the care of one person who had a pressure sore to see how it was being treated. Although the person was receiving regular checks from nursing staff, care records showed the person was not receiving pressure relief in line with the requirement of their care plan. We therefore could not confirm whether this sore was being treated correctly due to lack of appropriate records.

Good

Is the service caring?

Our findings

People told us staff were nice and treated them well. They said their privacy and dignity was respected by staff. People said if they had any worries of concerns they would speak to the staff or the manager and that they were confident they would be listened to.

The importance of treating people with dignity and respect was promoted with staff through several methods. It was considered during the interview process, staff meetings, and procedures were on display to remind staff of how to promote the organisations values. Training delivered as part of induction also helped staff to be aware of person centred approaches. Staff we spoke were able to give us good examples of how they ensured people's privacy and dignity was maintained. They demonstrated a good knowledge of the people they were caring for. Some staff provided one to one care to residents. Discussions with them revealed they were motivated and dedicated in their role and respected people's choices in terms of daily living and activities. For example one staff member told us "there are two of us purposefully employed to take people out. I love it. We cover all 7 days between us – 5 days each. I take them wherever they want to go."

We observed care over the course of the two days of the inspection. We observed staff gave residents choice with regards to their daily lives, such as what they ate, where they sat and what they wanted to do. We saw staff were able to confidently calm down any anxieties people had. For example we saw one person talking reassuringly to a person who had become distressed and confused, and not knowing where she was. They told her calmly where she was, that she was alright, and asked if she would like a cup of tea and then providing companionship whilst she settled down. We observed a pleasant and friendly atmosphere at lunchtime with staff responsive to people's individual needs. This gave us assurance there was a caring and respectful culture within the home.

We observed people living in the home were clean and tidy for example with neat hair and clean shaven. People we spoke with told us that their care needs were met by staff and they had regular baths and showers. Care records confirmed this to be the case.

The service had regards for people's individual needs for example in ensuring that cultural appropriate food was provided in line with their beliefs. There was also the opportunity for people to attend religious services on a regular basis, with a well-attended religious ceremony taking place on the day of our inspection.

Appropriate arrangements were in place to provide and ensure advocates were available for those who did not have family when important decisions needed to be made.

Relatives reported no restrictions on visiting people in the home. We saw evidence relatives had been consulted and involved in care reviews

We did note that the call buzzer regularly sounded throughout the home. This was often when the front door was opened rather than when somebody needed care or support. We found this noise to be quite disruptive and could have an impact on the wellbeing of residents.

Requires improvement

Is the service responsive?

Our findings

The home operated an electronic system for maintaining records of people's care. At the last inspection in January 2015 this system had just been implemented and we found records relating to each service users care were not always being accurately maintained. At this inspection we found although the system was better populated with information there still remained poor recording of care that needed to be addressed.

Sections on mental capacity were poorly completed within care plans making it difficult to establish whether people's capacity had been considered in decisions about their care and support. We also found a number of risk assessments and care plans were overdue their review date, for example one person's skin integrity risk assessment should have been monitored monthly but had not been done for two months. We saw some people were regularly having their fluid intake monitored. We identified in one person's care records, it stated they should have 1.5 to 2.0 litres of fluid per day but some recent entries showed they had significantly less than this. The manager told us care staff did not always fully document fluid intake. In addition, one person's care records showed they had moved into the home on 1 September 2015. There was a lack of personalised care plans and risk assessments in place for this person; the lack of information was created a risk that staff would not know how to deliver appropriate care. Another two people's care plans stated they should be subject to regular position changes every three to four hours but records did not consistently document this. We found inconsistencies dependant on the staff member entering the information. We were therefore unable to confirm whether these people received the required pressure relief. Following us raising this issue, the manager sent out a memorandum to staff reminding them to ensure all care tasks were robustly documented on the electronic care system in line with people's care needs.

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

People had a range of care plans in place which covered areas such as personal hygiene, continence, mobilisation and skin integrity which provided information to staff on how to deliver appropriate care. Staff told us they regularly read care plans from the computer units around the home to ensure they knew about people's plans of care and we observed this to be the case during our inspection. We saw evidence care plans and risk assessments had been responsive to people's needs for example dependency assessments had been updated following changes in people's needs.

Records of daily living with recorded on an electronic care system. Although these provided evidence of tasks, because of data input methods there was only very limited personalised information on their daily activity. The manager had recognised this was an issue and was looking and how more person centred information could be recorded. People were subject to regular checks in line with the frequency set out in their care plans to see for example hourly at night where required. Records showed people regularly had showers and/or bath as per their individual needs and preferences.

A number of systems were in place to help staff provide responsive care. Shift handovers took place to provide staff with the latest information on people's needs. We saw there were presently two handovers in the morning due to the shift patterns of nursing and care staff. The manager had recognised this was not ideal in ensuring the accurate transfer of accurate information and action was being taken to align shifts so only one handover needed each morning. Regular memorandums were sent to staff which they were required to read and sign to ensure they had current information on people's needs, and key care messages were transmitted to nurses via the electronic care record system to ensure they actioned any changes required to care plans following changes in people's needs.

We found a robust system had been put in place to regularly check that mattresses were set correctly. We found all three mattresses to be on the correct setting indicating the system was now working correctly.

People's social and spiritual needs were assessed. A programme of activities was provided to people. People generally spoke positively about the activities for example one person said how much they enjoyed the music man and another said "The entertainers are good, sometimes a comedian and sometimes signers." The activities available were communicated to people via an activities board. During the inspection we observed a religious service and motivation programme which were well attended and people appeared to enjoy.

Requires improvement

Is the service responsive?

Although there was a daily activities programme we found care staff did not have much time to provide social interaction and interactions were often task focused rather than person centred. Some people told us they were bored, for example one person told us "I want to move, I'm bored, I just watch telly. See what I mean." We noted that outside the planned activity sessions the atmosphere was often flat and was a lack of interaction and stimulation in the lounge. Some of these people were younger adults and we concluded more effort could have been made to provide person centred and stimulating activities.

A complaints policy was in place which was appropriately brought to the attention of people who used the service. Complaints were investigated by the manager and audited for any themes and trends. People told us they knew how to complain and generally said that management took appropriate action. We looked at how some recent complaints had been managed, we saw that clear actions had been put in place to help resolve the complaint and learn from the incidents.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in place. We found the provider had submitted most required statutory notifications to the Commission, for example notifications of serious injury or allegations of abuse. This helped the Commission regularly monitor the quality of the service. However we found one incident that had not been reported to us promptly. We concluded this was an isolated incident and warned the provider of its need to ensure all notifications were consistently reported to us in the future.

People and relatives spoke positively about the management at the home. For example one person said they regularly saw the registered manager and nominated individual and knew them by name.

We saw the manager was regularly visible throughout the home and conducted a daily walk around, this helped them to monitor how the home was operating and dealing with any emerging risks. We found staff morale was good and staff told us management were approachable and able to support them effectively. The home operated an on call system to ensure that management support was available out of hours.

The manager was honest and open with us about where the organisation currently was and about improvements which were required including ensuring reduced agency use and better documentation through better use of the computerised care record system. We saw the manager had worked hard to improve and set a consistent staff culture within the organisation. We concluded the lack of a stable and consistent nursing team was the most significant barrier to ensuring consistent high quality care within the home.

At the last inspection in January 2015 we found systems to assess, monitor and improve the service were not sufficient. Following the last inspection, we found a number of systems had been put in place by the registered manager to improve the quality of care provided by the home. For example new policies and procedures were being introduced and improved staff training

Care records were entirely computer based, and this allowed more in depth monitoring of people's care, although systems to ensure these systems operated correctly were not fully embedded. Overall we found a marked improvement over the number and quality of audits and checks undertaken by the home. Robust audits and checks on nutrition and weight, mattresses, infection control and building related checks were completed well.

The manager regularly looked at care records informally and there was evidence they were identifying issues and taking action to address. More structured care plan audits were undertake however most of these were overdue which meant they were not being carried out at the planned frequency. Although these looked at the quality of care plans and changes were made were deficiencies identified, they did not monitor all aspects of the computerised care system, for example whether care was documented in line with care plans. We found some issues in these areas which could have been identified and rectified by a more robust system of audit against a standardised format.

Regular medication audits were carried out on however these checks had not highlighted the discrepancies and concerns that we found. Where issues had been identified, these actions were not always signed off and there was no evidence of follow up competency checks following "speaking with staff" about issues found. Given we identified a number of concerns with regards to medication management this showed that this aspect of the system was not sufficiently robust.

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

Systems were in place to seek the views and feedback of people who used the service. People and their relatives reported that residents and relatives meetings took place although some relatives told us communication could be improved by the home. We looked at minutes from a recent 'residents'' meeting which showed people were asked for their views on activities, food and mealtimes. Annual surveys had been sent out to people who lived at the home in January 2015 and these were mostly positive.

Performance issues were identified through staff through staff meetings, appraisal and supervisions. We saw these had been used to improve staff performance. However supervisions were currently behind schedule. There were

Requires improvement

Is the service well-led?

no competency checks on nurses for example with regards to medication which could have been used to drive the organisation towards providing consistent and high quality nursing care.

A system was in place to record accidents and incidents with documentation showing that actions were put in place following incidents. The number of accidents and incidents was regularly monitored to look for trends and themes. We found these were generally well managed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to assess, monitor and improve the quality of the service were not fully in place. An accurate, complete and contemporaneous record in respect of each service user was not maintained.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users as the risks to associated with medicines were not appropriately managed.

The enforcement action we took:
We issued a warning notice requesting the provider become compliant with this regulation by 1 November 2015