Parkhaven Trust

James Page

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

The James Page nursing home provides nursing care for up to 36 older people in a single storey building in Maghull. The James Page nursing home is part of Parkhaven Trust, a registered charity providing a range of services for older people and people with dementia.
This was an unannounced inspection which took place on 21, 22 April 2016. The service was last inspected in April 2014 and at that time was found to be meeting standards.

There was a registered manager in post. 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.

We reviewed the way people's medication was managed. We saw there were systems in place to monitor medication so that people received their medicines safely. We found some medicines given 'when required' lacked supporting protocols and external medicines [creams] were not being recorded appropriately.
We told the provider to take action.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained. We asked people how their care was managed to meet their personal preferences and needs. People were satisfied with living in the home and felt the care of offered met their care needs. People we spoke with said they were consulted about their care and we saw some examples in care planning documentation which showed evidence of people's input.

We saw written care plans were formulated and reviewed ongoing. Some plans did not always contain necessary detail which meant it was difficult to follow the care. We discussed the care of one person who had a pressure ulcer and how the planning and ongoing monitoring could be improved.

We made a recommendation regarding this.

The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally by staff and from visiting senior managers for the provider as well as the Trust Board. We found these were developed to ensure effective monitoring and development of the service as well as helping to ensure standards were continually maintained.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and decisions made in the person's best interest.

The managers had made referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the applications were completed and were being monitored by the registered manager.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people.

Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Planned development / maintenance was assessed and planned well so that people were living in a comfortable environment.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each person's care needs and how they communicated these needs. People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care.

We saw people's dietary needs were managed with reference to individual preferences and choice.

People we spoke with said they were happy living at James Page. They spoke about the nursing and care staff positively. When we observed staff interacting with people living in the home they showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them although staff reported this was compromised by the amount of personal care being delivered.

We discussed the use of advocacy for people. There was information available in the home regarding local advocacy services if people required these.

Activities were organised in the home and these were appreciated by the people living at the home. We saw an activities programme. The staff member who organised these was motivated to provide meaningful activities. The home had developed an effective support network for relatives who contributed to ongoing projects in the home such as maintaining the garden.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw that a record was made of any complaints and these had been responded to.

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.

We found medicine administration needed improvement to ensure effective ongoing management as the provider's arrangements to manage medicines were not consistently followed.

We found that people had had risks to their health monitored. Some assessments and care plans did not always contain necessary detail to help ensure consistent outcomes for people's health.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were enough staff on duty to help ensure people's care needs were consistently met. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and care and treatment planned in their best interest.

The home supported people to provide effective outcomes for their health and wellbeing.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them.

People told us their privacy was respected and staff were careful to ensure peoples dignity was maintained.

There were opportunities for people to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Good

The service was responsive.

Care was planned with regard to people's individual preferences. We saw written care plans were formulated and regularly reviewed.

There were activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post who provided a lead for the home and was supported by an operational lead on a daily basis.

We found the management structure had clear lines of accountability and responsibility which helped promote good service development.

There were a series of ongoing audits and checks to ensure standards were being monitored effectively.

The Care Quality Commission had been notified of reportable incidents in the home.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes. These included regular meetings and other formal processes.

James Page

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 checked 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 was an unannounced inspection which took place on 21, 22 April 2016. The inspection was undertaken by an adult social care inspector.

We were able to access and review the Provider Information Return (PIR) as the manager sent this to us as part of the inspection. The PIR 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 also reviewed other information we held about the service.

During the visit we were able to meet and speak with five of the people who were living at the home. We spoke with five visiting family members. As part of the inspection we received feedback from three health and social care professionals who visit the home and who were able to give us some information regarding how the service supported people.

We spoke with eight of the staff working at James Page including nursing staff, care/support staff, kitchen staff, domestic staff, the administrator, the registered manager and operational manager.

We looked at the care records for four of the people staying at the home including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

Medicines were stored safely and were locked away securely to ensure that they were not misused. Staff had signed the Medicine Administration Records (MAR) to evidence medicines had been administered to people. Names of medicines were highlighted on the MAR which made the record easy to follow.

Although we found there were strong areas of good practice there were some anomalies on all of the four records we looked at that required further action to ensure all medicines were being administered safely. For example there were some omissions that meant tracking quantities of some medicines could be difficult. Dates and signatures for two medicines having been received were not recorded on the MAR. On one MAR a prescribed medicine was not recorded at all [this was added by the nurse at the time]. In another example a medication had been carried over from the previous month but there was no quantity recorded so it was difficult to audit the quantity in stock.

We asked about people who were on PRN (give when needed) medication; for example for pain relief. We found care plans had been draw up to support administration but these were generic and not specific to the person's individual medicine. There was therefore a lack of supportive information for these medicines and when they should be administered and evaluated. We also saw people who were using inhaler medicines to alleviate breathing conditions were not included in the PRN protocols. The importance of a PRN care plan is that it supports consistent administration and on-going review.

We saw that some people were being administered external medicines (creams). We asked how these were recorded and were told there is currently no method of recording the administration of creams. Parkhaven Trust were aware of this and were, at the time of the inspection, trialling a system of recording in a sister care home but the system had not been fully assessed for use elsewhere. There was therefore no record of external medicines being administered.

These findings were a breach of Regulation 12(1) g of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was one person having medicines given 'covertly' [without their knowledge in their best interest]. We saw that the nurse in charge was aware of best practice issues around this and these had been followed. The supporting care plan was clear and issues regarding consent had been clearly recorded.

As well as nursing staff administering medicines in the home other designated staff completed a Practical Competencies in Administration of Medication course and were regularly assessed for competency and good practice. We saw details of the training completed which was detailed and comprehensive.

Care records we saw confirmed that people were reviewed regularly by visiting GP's and this included medication reviews.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's

health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed regularly to help ensure any change in people's needs was assessed to allow appropriate measures to be put in place.

We saw that some immediate risks regarding people's health were not always assessed and planned with enough detail. For example we reviewed one person who had a pressure ulcer. We found difficulty in clearly identifying the progress of the wound and who had been consulted and involved in the care. This was primarily because there was no care plan available which clearly prescribed the care and treatment but also the wound care charts were difficult to follow. We discussed ways in which the monitoring of wounds could be better evidenced. The registered manager showed us a new wound chart they had sourced and said they would introduce this in the home.

We also saw a plan for a person with an on-going health condition that did not specify action needed to both identify and take necessary action in case of a medical emergency. The operational lead told us that recent audits had identified issues around detail in assessments and care plans and this was being worked on.

We would recommend that all assessments and planning of care around risk are detailed enough to meet bests practice.

When we visited the home we checked to see if there were sufficient staff to carry out care in a timely and effective manner. We were told by the operational lead that there had been some issues with nursing staff leaving and having to be replaced and that this had now been addressed, particularly as the registered manager (also a nurse) had returned to the home following a period of leave. The difficulties over the past year with staffing were acknowledged in the Trust's development plan for the previous year. The Trust had also been proactive in developing senior roles for care staff to support the nurses in clinical areas such as medicine management.

There were 33 people living in the home at the time of our inspection. There was at least one nurse (including the registered manager) on duty on both days of the inspection together with seven care staff, including two 'care supervisors' (senior care staff). These figures fluctuated for late shifts and nights. There were ancillary staff such as an administrator, kitchen staff (all day), and domestic cover. When we looked at the duty rota we saw these staffing figures were reflected for the week of our inspection and for the two weeks before this.

The observations we made evidenced staff were available. We observed staff attending to people and supporting them to eat and drink as well as assisting with aspects of personal care. One staff told us, ''We are not rushed and can spend time with residents when we deliver care.'' all staff, however, commented that the dependency of people living at James page had increased over the past few years. Staff told us they had less time to spend socially with people due to the high level of personal care people needed. This was acknowledged by the managers at the inspection and was also seen on a recent Trustee audit carried out in November 2015 which said, 'dependency is increasing and this has implications for skill mix'.

Currently the home does not have any formal monitoring tool for assessing levels linked to people's dependency of care need. We discussed with the managers the need to develop this on-going to ensure staffing in the future would continue to match the needs of people living in the home.

During the inspection we made observations in the day area/lounge and spoke with people. The feedback was consistent in that people felt they were supported well and there were enough staff available. One

person said, ''I get good care. There are enough staff for me.'' Another said, ''I'm looked after well generally. Staff always take their time with me.'' These comments were echoed by relatives we spoke with. One said, ''the care is excellent. The layout of the home helps and staff always take time to assist (relative). There's not always time for socialisation however.''

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two staff files and asked for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. The recruitment process included notes of staff interviews which included questions asked to prospective employees in many areas of safe care including recognition and reporting of abuse.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the Local Authority safeguarding team were available in the nursing office.

There had been a safeguarding incident recently concerning unexplained bruising for a person. This had been followed through with the safeguarding team from social services. It was clear the home had worked well liaising with the safeguarding team to ensure issues were followed up and any lessons could be learnt.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. Maintenance audits were conducted by the Trust's maintenance manager and reports made to the Board. We saw the general environment was safe.

We saw how accidents and incidents were monitored in the home. All accidents were recorded and sent for review by senior managers up to Chief executive Officer level. Statistics for accidents and incidents were on the agenda at Board meetings and analysed for any trends.

A 'fire risk assessment' had been carried out and updated at intervals. The operational lead was also the 'fire marshal' and had attended relevant training. We saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. We spot checked other safety certificates for electrical safety, gas safety and kitchen hygiene and these were up to date. This showed good attention with regards to ensuring safety in the home and on-going maintenance.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can 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 and hospitals 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.

We found requirements were being met and people who lacked capacity to make certain decisions were assessed appropriately. For example we looked at one person who was being administered their medications 'covertly'. This meant without their knowledge. We saw that the person had been carefully assessed using the appropriate assessment tool regarding their capacity to consent to their medication administration and assessments had also included input from the pharmacist and GP. It was felt the person needed the medicine in their 'best interest' to ensure their health was maintained. This process showed a good understanding of the principals of the MCA and how they should be applied to ensure people's rights are protected.

We saw other examples where restrictions had been applied regarding people's care; for example when bedrails were in use. We found examples where people had given their consent for such use or there had been an assessment made of the person's capacity to consent and, if required, a 'best interest' decision had been taken to ensure safe care. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made and we could see the person involved had been consulted regarding this and, when necessary, the person's relatives. The DNACPR form we saw contained an assessment of capacity by the GP.

The registered manager had made 17 applications to the local authority for people who lacked the capacity to make a decision to stay in the home. We reviewed the applications for two people and saw the application had been made appropriately with the rationale described. We saw the assessment by the local authority was delayed on these applications and the registered manager said they would ensure the issue was followed up.

We observed staff provide support at key times and the interactions we saw showed how staff communicated and supported people and asked their consent to care. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.
We received feedback from a health and social care professional during the inspection who was involved in

the support of people at the home. We were told the home was good in that staff would listen to advice and put any necessary provision on place regarding people's on-going health care needs. We discussed the care of one person and the professional was pleased that staff were acting positively and proactively when needed. We were told, ''Generally residents are looked after well. There is a good atmosphere in the home.''

We reviewed the care of three people in detail on our inspection as well as asking about aspects of other people's health care and how effective this was. Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were well documented and followed through. For example one person had a specific medical diagnosis requiring careful monitoring and awareness by staff of key areas of risk. We saw these were documented on assessments and follow up health checks made. The person told us they were supported by staff to attend routine medical appointments and we saw their health status was being monitored effectively.

We saw that care records had been regularly reviewed and updated with reference to any external health support needed.

People we spoke with and relatives told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff.

The Provider Information Return (PIR) told us:

'All employees undergo supervision and appraisal; this includes direct observations of performance and work practice, assessing communication skills and professional relationships between service user and staff member. Specialist training has been provided including MCA and DoLS, specialist dementia training focusing on awareness communication and nutrition and hydration, wound care and healing, diabetes awareness, catheter care and venepuncture to improve staff knowledge in providing care for specific needs. Staff are taking part in end of life care - the six steps with the (local) Hospice'.

The operational lead supplied a copy of a staff training calendar and records for training undertaken and planned. We saw training had been carried out for staff in 'statutory' subjects such as health and safety, safeguarding, infection control and fire awareness.

The registered manager informed us that many care staff had a qualification in care such as QCF (Qualifications Credits Framework) and confirmed that 96% of staff had attained a qualification.

Staff spoken with said they felt supported by the managers and the training provided. They told us that they had had appraisals and there were support systems in place such as supervision sessions. We asked about staff meetings and we were told that issues get discussed at daily handover as well as formal staff meetings arranged on a regular basis. Staff reported they were asked their opinions and felt the managers did their best to act on feedback they gave and this helped them feel acknowledged and supported.

We observed the breakfast and lunch time provision in the lounge/dining room. At breakfast time there was staff input in the dining area and we saw each person had been given a breakfast and had drinks placed in front of them. We were told us there was no problem with the provision of meals and people could choose to have their meals in their rooms if they wished. There were day areas on each unit which could also be used for meals. People we spoke with told us that the meals were good and they were generally satisfied with meals provided. We saw the cook was actively involved in speaking with people and was knowledgeable regarding peoples individual dietary preferences. We saw that meals were a sociable

occasion and staff had time to assist people with their diet.

Good

Is the service caring?

Our findings

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding. We asked people we spoke with if they were treated with dignity, respect, kindness and compassion. We received positive comments. One person said, ''Staff are very good and will take time with my appearance – I've had my hair done today and staff will comment.'' A relative commented that the layout of the home helped promote privacy and independence. All bedrooms were en-suite which they felt contributed to this. It meant that people's personal care could be carried out with dignity. Another relative said, ''Staff are very positive and caring. Some go above and beyond and will come in off their days off to help socialise and support (people). They are all lovely.''

People told us they felt they were listened to and staff acted on their views and opinions. We saw that resident and relative meetings had been held. We saw one held most recently and this was attended by the Trust's Chief Executive Officer to get feedback from people living at the home. Surveys were also sent out to canvass opinions. Comments received in the 2015 survey included "The atmosphere is one of a caring compassionate home."

We made some observations of lounges over the two days of the inspection. Staff were seen to have very positive relationships with people and encouraged a good communal atmosphere. The interactive skills displayed by the staff were positive and people's sense of wellbeing was evident.
Throughout the inspection we observed staff supporting people who lived at the home in a timely, dignified and respectful way.

We asked about visiting from relatives. We asked if there were any restrictions and were told relatives and visitors were free to visit at any time. One relative said, ''Staff are open and friendly.'' The staff we spoke with had a good knowledge of people's needs and spoke about the people they supported with warmth and understanding.

We met with one relative whose relation had died at The home. We were told the care had been "excellent'' and they had felt well supported by all staff. Staff had supported good communication with external professionals for any extra support.

We discussed the use of advocacy for people. Advocacy information was posted in the home
There were no examples of anyone in the home currently using an advocate. The operational lead was able to discuss examples of using the local advocacy service in the past to support people living in the home and their relatives.

Good

Is the service responsive?

Our findings

We asked people how their care was managed to meet their personal preferences and needs. People were satisfied with living in the home and felt the care offered met their needs. Most said they felt involved in their care in that staff asked them regularly how they felt and whether their care needed changing in anyway.

Care files we looked at were updated to reflect people's current care needs although the detail of these we found could be improved in some instances. We saw they were being reviewed by nursing and care staff regularly. We saw evidence of people being involved in their care planning. For example we saw that in some instances people had signed their care plan and in others they had signed to say they had seen their care plan or it had been discussed with them. We also saw entries to say care had been discussed and updated with relatives where necessary.

When we spoke with people they told us they felt involved in the planning of their care. Most confirmed that staff regularly asked them how they felt or if they were okay, and all said they felt they could communicate their feelings or likes and dislikes to staff. Most residents could not recall or tell us the contents of their care plan but were able to say how the care being delivered met their immediate nursing or care needs. All of the relatives we spoke with told us they were always kept well informed regarding any issues with their relative. They had been involved in care reviews with staff from the home at various stages and these had sometimes included formal reviews of care with social workers input.

Some of the people we spoke with had full capacity to plan their day and make their own decisions. They told us they were happy living at the home. We saw that people were engaged in activities and there was a planned activity schedule organised by a designated staff member. The programme was displayed. A relative said, ''The activities are good. They are organised and creative.'' We were told about music sessions by outside entertainers, arts and craft groups organised by volunteers, a reading group (lead by the CEO) and more day to day events such as being encouraged to spend time in the garden. During the inspection the garden was being prepared by relatives who had volunteered their time.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. The PIR told us, 'The Trust actively promotes and encourages complaints, concerns or compliments and the procedure is clearly displayed in the foyer at James Page House for easy access. This is a private and confidential procedure and a response is given within a reasonable time period. The Trust endeavours to learn from complaints, concerns or compliments to ensure the service provided is responsive'.

We saw there were good records of complaints made and these were audited and discussed at board level. One relative commented, "I've never had to complain as things are sorted out really quickly.'' We saw that complaints had been investigated and responded to by the managers of the home.

Good

Is the service well-led?

Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The managers were able to evidence a series of quality assurance processes and audits carried out internally and externally from senior managers, managers of other services in the Trust and from Trustees. These processes have generated a series of developments over the recent years to improve the quality monitoring in the home.

There was a registered manager who was supported by an operations lead. Both were present throughout the inspection and are in the home on a daily basis. There was a clear management structure supporting the home with all levels of management and supervision having active input into the home including the CEO. We were told by both registered manager and operational lead that the Trust had very clear systems in place to monitor standards and these included a strong emphasis on feedback from people using the service.

The PIR for the home stated, 'Parkhaven Trust promotes an open and fair culture. The Chief Executive actively and regularly communicates with staff. A monthly newsletter is circulated and includes feedback from board meetings and any other updates or news from around the Trust'.

We saw some of these communications including the latest business plan for the Trust which included reference to James Page. The open culture encouraged by the Trust was also exemplified by a recent commitment to an external quality audit called 'The Workplace Wellbeing Charter National Award'. This involved an assessment of the way the Trust operates in communicating with staff and providing a positive workplace. The assessment concluded, '(The award) shows you are forward thinking in cascading wellbeing practices throughout the organisation'.

From the interviews and feedback we received, both registered manager and operational lead were seen as open and receptive.

We looked at and reviewed some of other processes and quality assurance systems in place to monitor performance and to drive continuous improvement. The operational lead was able to show us a series of quality assurance processes and audits carried out internally to support ongoing monitoring. For example the regular medication audit, care plan audits and various health and safety and environmental audits. This had helped to ensure the home was being monitored in key areas.

We saw audits had been carried out on housekeeping, infection control, nursing equipment, financial audit, care planning, accidents and incidents and medication. These were backed up by Trustee' audits who visited on a six monthly basis. This provided an opportunity for Trustees to speak with staff, meet service users and families and give recommendations or actions that the Trustees deem appropriate. The information was fed up to the Trust Board who met on a regular basis to evaluate and set any action / goals needed for further development.

These audits were supported by some external monitoring and auditing by, for example, Liverpool

Community Health (LCH) regarding infection control and the local council environmental health department. LCH had visited in October 2015 and found the home compliant in managing infection control. Recommendations made at the time had been acted on.

The managers were aware of incidents in the home that required The Care Quality Commission to be notified of. Notifications have been received to meet this requirement.

These systems had assisted the registered manager and operational lead to have clear priorities for the home. The operational lead said key issues included developing care planning to include greater detail and further evidence of consent, develop standards and training for staff around end of life care, and to continue to recruit nursing staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found medicine administration needed improvement to ensure effective on-going management as the provider's arrangements to manage medicines were not consistently followed.