

Rosecroft Residential Care Home

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Inspection report

66 Plaistow Lane
Bromley
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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Requires Improvement



Is the service responsive?

Inadequate



Is the service well-led?

Requires Improvement



Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Rosecroft Residential Care Home is located in the London Borough of Bromley and is registered to provide accommodation and personal care for up to 20 older people mostly with dementia. There were 15 people living at the home when we visited.

This was an unannounced inspection. During our inspection, we spoke with ten people living at the home, two groups of visiting relatives, three members of care staff, one kitchen assistant, the deputy manager and the

Summary of findings

registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We carried out three inspections in April, June and August 2013. At the April inspection we had concerns about the standards of care in the following areas; care and welfare of people using services, management of medicines, supporting staff, records management and how the quality of the service was assessed and monitored. We carried out a “follow up” inspection in June. Although we found some improvements had been made we still had concerns in relation to the care and welfare of people using services and the management of medicines. We took enforcement action against the provider. We carried out a further “follow up” inspection in August 2013 and found that the provider had made the improvements required.

People told us they were happy living at the home and their relatives told us they felt their family members were well looked after. People said the staff were “good” and that they had no concerns. We observed positive interactions between staff and people using the service. We saw that staff treated people with kindness and respected their privacy and dignity.

Systems were in place to protect people from potential harm or abuse and staff we spoke with knew of their responsibility to safeguard people.

We found that healthcare professionals such as general practitioners (GPs), dentists and district nurses were involved in people’s care and treatment. However, there was no evidence to demonstrate that people and their relatives were involved in making decisions about the care that they received. Staff did not always follow the requirements of the Mental Capacity Act (2005), and people’s liberty may have been restricted unlawfully, without regard to the Deprivation of Liberty Safeguards (DoLS).

We found that people’s healthcare needs were assessed and each person had a care plan. However, where risks were identified, appropriate risk assessments and management plans were not always in place. Appropriate support was not in place to ensure people ate sufficient amounts to maintain a healthy lifestyle. .

There were arrangements to deal with potential emergencies and staff were aware of actions to take in the event of an emergency.

Staff we spoke with told us there was not always enough staff members available to safely meet people’s needs. We found that appropriate support was not always in place for staff in areas such as induction, supervisions, annual appraisals and team meetings.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version 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?

The service was not safe. We found that the service was not always meeting the requirements of the Mental Capacity Act (2005) code of practice and Deprivation of Liberty Safeguards.

Risks associated with people's care were not always assessed and appropriate plans were not always in place to reduce these risks.

The provider did not have a safe recruitment system in place and staffing levels were not always sufficient to meet people's needs.

Inadequate



Is the service effective?

The service was not effective. Although staff received training, they were not always supported to deliver care that was safe and to an appropriate standard through induction, supervision, appraisals and team meetings.

People were given a choice of meal; however they were not always supported to eat safely.

Healthcare professionals such as general practitioners (GPs), dentists, and district nurses were involved in people's care.

Inadequate



Is the service caring?

The home was not consistently caring. People, their relatives and others involved in their care were complimentary about the care and support provided. They told us that staff were ok, lovely, friendly and provided them with the care and support they required.

People's privacy and dignity were maintained when staff provided personal care such as bathing.

People, their relatives and those that mattered to them were not always involved in their care and support planning. Where people required additional support to make decisions about their care and support, access to an independent advocate was not available.

Requires Improvement



Is the service responsive?

The service was not responsive to people's needs. People's care and support plans were not always reviewed in line with the provider's timescales, which increased the risk of people receiving inappropriate care.

The relatives we spoke with knew how to complain if they were unhappy with the service. The provider had received one complaint in the past 12 months. However, we found that people were not always encouraged to make a complaint because information was not available in formats that met their needs.

Inadequate



Summary of findings

Is the service well-led?

The service was not well led. There was no support in place for the registered manager to drive improvement.

The systems for monitoring the quality of the service were not effective, and did not result in improvements to the service people received. Staff feedback and complaints were not taken seriously to improve the quality of the service.

Requires Improvement



Rosecroft Residential Care Home

Detailed findings

Background to this inspection

This inspection was carried out on 14 July 2014. The inspection team consisted of an 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 service.

We carried out three inspections in 2013, April, June and August. At the April inspection we had concerns about the standards of care in the following areas; care and welfare of people using services, management of medicines, staff support, records management and how the quality of the service was monitored. We carried out a “follow up” inspection in June. Although we found some improvements had been made we still had concerns in relation to the care and welfare of people using services and management of medicines. We took enforcement action against the provider. We carried out another “follow up” inspection in August 2013. We found that the provider had made the improvements required.

Before our inspection, we reviewed the information we held about the home and contacted the local authority contracts monitoring team to obtain their views. The provider did not properly complete the Provider Information Return (PIR), so we were unable to use this to plan our 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 reviewed other information we held about the service such as any statutory notifications we had received.

At the inspection visit, we spent time observing how people were being cared for, spoke with ten people using the service, two groups of relatives, three care staff, one kitchen assistant, a deputy manager and the registered manager. We also spoke with a health professional and a volunteer.

We looked at four people’s care records, five staff recruitment records and 14 staff training records. We also looked at other records relating to the management of the service, such as staff duty rosters, policies and procedures, menus, activities planners, feedback forms and various audits.

Is the service safe?

Our findings

The provider did not have adequate staff in place to provide the appropriate support people required. One person told us that they did not require personal care, however during night time when they requested support, “staff do not respond quickly.” We found that staffing levels were fixed and there was no system of assessing the number of staff required against people’s needs, which resulted in inadequate staffing levels at certain times. For example, two people using the service required the support of two staff for personal care. Therefore there was a risk that if both individuals needed personal care and support at the same time, there would not be enough staff to support them or others living at the home.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the manager was mostly performing the role of care assistant due to staff shortages and this was affecting the management of the home. Staff told us that “more could be done to improve the staffing levels.” This showed that staffing levels, staff skills and knowledge were not always adequate to meet people’s needs.

The manager informed us that three care staff worked each morning and afternoon shifts and two waking night staff worked during the night; in addition they had a part-time kitchen assistant, a cleaner and a deputy manager. The staffing records we looked at confirmed this.

Staff recruitment was not always robust. We looked at five staff recruitment files. All staff had criminal records checks on file. However, we saw that one staff member had only one reference and another did not have any references on file. The manager was unable to find this member of staffs references upon request. This showed that the provider did not always have a safe recruitment process to ensure that all staff employed were suitable to care for people using the service.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at four people’s care records which included areas such as mobility, nutrition and personal care. Where risks were identified there was not always adequate guidance for staff to manage or reduce these risks. For example, we saw that one person had dementia and it was

stated in their daily care notes that they were getting confused more than usual. The notes indicated that care and treatment could not always be delivered because of the person’s behaviour and there was no behaviour risk assessment with guidance for staff to follow. Therefore the individual was at risk of receiving inappropriate care and support because their care had not been risk assessed or planned for.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager informed us that an individual’s behaviour was being assessed annually by an external specialist organisation. However this information was not available in their care file to provide staff with appropriate guidance and to ensure their needs were met.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found that the home was not always meeting the requirements of the Mental Capacity Act code of practice and Deprivation of Liberty Safeguards. The manager informed us mental capacity assessments had been conducted for everyone using the service and that 10 people were found not to have capacity due to dementia.

After our inspection, the manager sent us a copy of a person’s mental capacity assessment form. This document was a general assessment which was not for a specific decision, one of the key elements of the Mental Capacity Act (2005). We saw that the front door had a coded key pad to which people’s relatives had the code. Staff told us that none of the people who used the service were given the code; therefore people were not able to leave the service on their own when they wished. The registered manager told us that DoLS did not apply to anyone using the service however they did not refer to a recent Supreme Court judgement which broadened the scope of the DoLS. This showed that the provider was not aware that this may constitute unlawful deprivation of people’s liberty.

Records showed that most staff had been trained in the requirements of the Mental Capacity Act (2005), however one of the four staff we spoke with could not demonstrate they understood the key principles of the Act and how to apply these when supporting people. One staff member told us, “Mental capacity is when the brain stops.”

Is the service safe?

This was breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had safeguarding adults, Mental Capacity Act (2005) and whistle blowing policies which were made available in the staff office. The safeguarding adult's policy we looked at was not up to date and did not include reporting suspected abuse to the Care Quality Commission (CQC). Most of the provider's policies, such as the whistle blowing policy, were not dated therefore we were unable to confirm if the information was up to date and regularly reviewed.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service were unable to tell us whether they felt safe or not due to their dementia however relatives told us they felt people were safe in the home. One relative commented, "We have not noticed any bruising and have felt our family member is settled in the home in the past four years." Staff and the registered manager knew of their responsibility to identify and report abuse.

Staff knew of the emergency procedures to follow and told us that they would contact emergency services for example if there was a fire or someone had an asthma attack. Staff training records showed that staff had received training in fire safety and first aid to ensure they had appropriate skills to support people in the event of an emergency.

Is the service effective?

Our findings

The manager informed us that all new staff completed an induction when they commenced work. A new staff member confirmed they had one week induction which included shadowing, training and meeting residents on a one-to-one basis. However, most staff files did not include any information to confirm they had completed induction before starting work at the home. Due to the lack of documentation, we were unable to confirm that people were cared for by staff who had received appropriate training and support before they commenced working at the home.

The manager informed us that staff meetings were undertaken every two months. The minutes of the meetings showed that this was not always the case. We saw four meeting minutes dated June, September, November 2013 and May 2014. The deputy manager informed us that minutes of meetings were sometimes not documented and staff could not confirm how often these meetings took place. Due to lack of documentation we were unable to evidence that team meetings were taking place in line with the provider's policy and to ensure staff were supported to deliver care that was safe and met people's needs.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at 13 staff supervision records. It was the provider's policy to carry out supervision sessions for each staff member every two months. The records showed that four staff received their last supervision in March 2013, five staff in August 2013, three staff received one supervision in 2014 and one staff received two supervisions in 2014. We found that staff did not receive annual appraisals to ensure their performance and development was being monitored.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During lunch time, we saw that people were offered a choice of meals. We found that all food served in the home such as mashed potatoes, macaroni cheese, soup and vegetables were ordered on weekly basis from a catering company. People we spoke with and their relatives told us that they were not consulted when these changes were

made. One person said, "They do not ask me what I want to eat, and I eat if I like it or leave it." This showed that people's views were not sought or taken into consideration when making changes to the service they received.

We observed that a staff member who was supporting one person to eat left the individual halfway through their meal to support another person. The registered manager told us that one person was always drowsy due to the medicines they were taking. During lunch time, we observed that the person was falling asleep in the middle of having their meal, stooping forward with their cutlery pointing into their eyes and no staff member asked them if they would like to be supported to eat safely. This showed that appropriate support was not always in place to ensure that people's needs were met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the care plan of one person who had been diagnosed with diabetes. We noted that the care plan did not provide staff with any guidance on how to ensure the individual's specific nutritional needs should be met. Due to lack of documentation, the individual was at risk of receiving unsafe or inappropriate care in the event where new staff or staff unfamiliar provided care and support.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with were generally aware of people's dietary needs. For example, they told us that some people were diabetic and were therefore not allowed to have sugar, and were given fresh fruits. The kitchen assistant told us to cater for diabetic people they prepared a different cake without sugar to ensure these people's needs were met.

People were unable to comment on whether staff had appropriate skills to support them or not. A health professional involved with the service told us that staff followed instructions regarding people's care and support.

Staff training records showed that staff had completed mandatory training in areas such as safeguarding adults, food hygiene, infection control, health and safety fire safety, and dementia awareness. It was the provider's policy to review these training courses annually and we found that this was not always done in line with their required time frame. The registered manager showed us documents to

Is the service effective?

evidence future training courses which had been booked for staff. However, since this training had not taken place at the time of our inspection, we were unable to confirm that all staff received training in line with the provider's policy.

Healthcare professionals such as a general practitioner (GP), dentist, chiropodist and district nurses were involved in people's care. We found that people were supported to attend healthcare appointments either by their relatives or staff to ensure their individual health needs were met.

Is the service caring?

Our findings

We found that most people at the home were unable to make specific decisions for themselves due to their dementia. The registered manager told us that some people who used the service had no relatives involved in their care and support. However, no one using the service was being supported by an independent advocate to make decisions that mattered to them.

The manager told us that they involved people who had capacity and/or their relatives in their care planning, but we did not see evidence that people were involved in their care plan reviews.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Family members were kept informed of their loved one's well-being. Visitors told us that they were updated with relevant information when required, for example, when their relative felt unwell.

People's care plans did not always demonstrate that the care provided was person centred to an individual's needs. For example, in one person's care plan, we noted a different name was used and staff could not explain the reason behind this. Risk assessments records we looked at had been standardised and did not specifically address people's individual needs. This showed that people were at risk of receiving care and support that did not meet their needs due to inappropriate documentation.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that staff interacted well with people and explained why certain actions needed to be taken. For example, staff explained to one person why they needed to elevate their foot on a stool to minimise the risk of a swollen ankle.

Most people who used the service had dementia. The registered manager informed us that there was no activity coordinator in post and that staff were responsible for engaging people in activities. We saw that the weekly activities planner and the menu displayed in the dining room were in pictorial formats. We noted that there was music playing most times during the day and people sang along in a cheerful manner. In the morning, we saw that

some people were engaged in a ball game but this was not structured. In the afternoon, another member of staff engaged people in a game of skittles, similar to bowling. This was being played in the lounge where most people did not take part, but were asleep. This showed that the activities being organised may not have been stimulating enough and that people's needs were not always taken into consideration when planning their care.

People's care and support plans we looked at were not always reviewed in line with the provider's annual timescales. Therefore there was a risk that the care and support provided was not in line with people's current level of need.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us they felt people were happy at the home. A health professional said, they found people to be well cared for and that the home had a relaxed atmosphere. A volunteer who visited the home once a week to support people with their faith commented that they found staff very welcoming and friendly. People told us that staff were "good".

Three of the four care plans we looked at included people's life history which helped staff to understand people's lifestyle choices. The care plans also included people's likes and dislikes such as their preferred names. We found that the home recently organised a beach trip for people and most people told us they enjoyed the trip.

People's privacy and dignity was respected. Staff told us they maintained privacy and dignity by knocking on bedroom doors before entering, and closing bathroom doors when providing personal care such as bathing. We observed two staff members transferring one person from their wheelchair with a hoist. Staff explained to them at every stage the actions they were taking, ensuring their clothing covered them appropriately.

Care and support plans showed people's relatives and friends visited them at the home and we observed that three sets of relatives visited people during the time of our inspection. Relatives we spoke with told us that they did not have any problems coming to the home to visit their loved ones. A Catholic nun also visited two people to support them with their faith once a week.

Is the service responsive?

Our findings

Four people at the home had an advance care plan in place however none of the care plans had a signed or authorised "Do Not Attempt cardiopulmonary Resuscitation" (DNAR) form by their general practitioner (GP) to ensure that their end of life wishes were respected.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people and their relatives told us that they knew how to complain. One person said, "We just call the staff, whoever is present." We noted that there was no information available in the communal areas to inform people of how to make a complaint in formats suitable to their needs. The service user guide we looked at did not include any information about how to make a complaint. The registered manager informed us no residents' or relatives' meetings were held to gather people's views about the home including raising concerns. Therefore people and their relatives were not always encouraged to raise their concerns or complaints with the provider.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had received one formal complaint in the past 12 months. The complaint document we looked at showed that appropriate action had been taken to ensure people using the service and their relatives were satisfied with the outcome.

The registered manager told us that questionnaires had recently been distributed to relatives and healthcare professionals to complete for this year's satisfaction survey. We saw that four of the feedback forms had been returned from relatives and five from healthcare professionals with some dated May 2014. The results of the survey had not yet been analysed. The four feedback forms we looked at showed relatives were mostly happy with the service provided and one comment included, "Residents always look smart and clean and cheerful and staff are lovely to deal with." Relatives also stated there was room for improvement in certain areas. For example, one relative stated they were not aware of how the home takes into account people's likes or dislikes or how people would like things to be done for them.

People did not always receive the care and support they required. At the time of inspection we observed that people's clothes were not always clean. We saw that a number of male residents' shirts or trousers were neither clean nor ironed. We also saw one person drinking from other people's cups, without staff noticing or encouraging them to stop.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service well-led?

Our findings

Various internal audits were being carried out by staff in areas such as infection control, medicines, health and safety, and kitchen audits. We were unable to determine the frequency of these audits as only one copy of each audit was given to us. We saw that most of these audits did not identify any shortfalls and this contradicted what we saw at the home. For example, we saw a dirty non-slip bath mat in one of the shower rooms which we drew staff attention to and this was immediately removed. The health and safety audits did not identify watermarks we saw on the ceiling in the lounge, or furniture that was not in good condition. We found that although these audits were being carried out they were not effective and did not identify issues that needed addressing.

The provider did not have a chef, an activities coordinator or a housekeeper in post at the time of our inspection. Minutes of supervision meetings identified that some staff were having difficulties with handling food, leading activities or the laundering of clothes. We saw that the supervisor informed staff that nothing would be currently done about their complaints, but to carry on performing whatever duties they had been allocated. This showed that people were at risk of receiving inappropriate care and support and staff feedback was not used to improve the quality of the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that an area manager and a consultant from the provider organisation who used to support the registered manager were no longer in post. There was no senior management involvement in the home and no managers' meetings were being held to support the registered manager to drive improvements. The registered manager we spoke with explained the difficulties they were having in the role. They told us they had to cover staff shortages regularly with the deputy manager and this was preventing them from performing their managerial duties.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a registered manager in post who was supported by a deputy manager. People and their relatives knew the management team and told us they felt comfortable speaking with them. Most staff told us their managers were approachable and they felt comfortable to raise any concerns with them. The local authority told us they had noticed a recent deterioration in the quality of care at the home. They told us that the registered manager could benefit from more support.

We found that a fire safety audit was carried out in February 2014 and some areas of improvements were identified. This included fire doors to be set to the required standard including self-closing devices, fire detection and smoke alarm devices to be in place and the basement ceiling to be brought to standard. We found most of the recommendations from the audit had been completed apart from the basement ceiling.

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	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9(1)(a)(b)(i)(ii)(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.</p> <p>The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p>Regulation 10(1)(a)(b)(2)(b)(i)(c)(i)(e)(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.</p> <p>The registered person did not have effective systems in place to monitor the quality of the service delivery.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment</p> <p>Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment.</p> <p>The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.</p>

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

Regulation 21(1)(a)(i) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

The registered person did not ensure that an effective recruitment procedure was in place.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Staffing

The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

Regulation 23(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting workers

The registered person did not have suitable arrangements in place in order to ensure that staff received appropriate support in relation to induction, training, supervision, professional development and appraisals.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>Regulations 20(1)(a)(b)(i)(ii)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records</p> <p>The registered person did not ensure that people and staff records were accurate and fit for purpose. Records could not be located promptly when required.</p>

The enforcement action we took:

Warning Notice, Moderate impact to be met by 10 October 2014.