Abdul Khan

The Branches

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 10 December 2015 and was unannounced. This meant that the provider did not know we would be visiting.

The Branches is a 24 bedded care home providing residential care. The service does not provide nursing care. The service is based in a converted building, with all of the communal areas on the ground floor and bedrooms situated on the ground floor and first floor. At the time of the inspection 23 people were using the service, most of whom were living with dementia.

There was a registered manager in place. 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.

The building was clean and appropriately maintained. However, items were inappropriately stored in communal and food storage areas in a potentially hazardous way. This also meant that some areas did not look homely for people living at the service. The registered manager said that they carried out checks and audits to several areas of the service, but did not keep records of these that could be used to monitor trends or for other people to examine.

These were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

Risks to people were assessed and care plans were in place to minimise them. This helped to keep people safe.

People were supported by staff that had been appropriately recruited through a robust selection process. Staff had to complete induction training before they could support people.

People were supported to access and administer their medicines safely, but we made a recommendation about recording information on 'as and when required' medicines for people who have difficulty communicating.

Staff received suitable training, supervision and appraisal to enable them to appropriately support people and felt that they could ask for more support if they needed it. We made a recommendation about medicines training.

Staff understood and applied the principles of the Mental Capacity Act, and were aware of people's rights when they could not consent themselves.

The service worked with external professionals to support and maintain people's health.

People were treated with dignity and respect. Staff knew the people they supported well, and people clearly enjoyed the time they spent with staff. Staff supported people in a kind and caring way.

The service would assist people with advocacy services if needed.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received. Plans were reviewed to ensure that preferences and needs were up to date.

People had access to activities and had opportunities to socialise with other people. People clearly enjoyed spending time with each other in the lounge and during meals.

The service had a clear complaints policy that was applied when issues arose. This was publically displayed so that people and relatives were aware of it.

Feedback was sought from people and staff in order to monitor and improve standards.

Staff felt supported and included in the service by the registered manager and provider, and said they would be confident to approach both with any issues they had.

The registered manager understood their responsibilities in making notifications to the Commission.

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.

The building was clean and appropriately maintained. However, items were inappropriately stored in communal and food storage areas.

Risks to people were assessed and care plans were in place to minimise them.

People were supported by staff that had been appropriately recruited and inducted.

People were supported to access and administer their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received supervisions and appraisals however, we made a recommendation about medicines training as this was overdue.

Staff understood and applied the principles of the Mental Capacity Act and consent.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

Staff knew the people they supported well, and people clearly enjoyed the time they spent with staff.

The service would assist people with advocacy services if needed.

Is the service responsive?

Good

The service was responsive.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received.

People had access to activities and had opportunities to socialise with other people.

The service had a clear complaints policy that was applied when issues arose.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits undertaken by the registered manager were not recorded so it was not possible to see how these were used to maintain standards.

Feedback was sought from people and staff in order to monitor and improve standards.

Staff felt supported and included in the service by the registered manager.

The registered manager understood their responsibilities in making notifications to the Commission.

The Branches

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 December 2015 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team consisted of an adult social care inspector.

The provider was not asked 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 information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and Healthwatch to gain their views of the service provided at the service. Healthwatch England is the national consumer champion in health and care.

The people who used the service were not always able to verbally communicate what they thought about the home and staff. Therefore we spent time observing how the staff interacted with and supported people. We spoke with one visiting relative. We looked at three care plans, Medicine Administration Records (MARs) and handover sheets. We spoke with five members of staff, including the registered manager, the senior carer, and care assistants. We looked at four staff files, which included recruitment records. We also completed observations around the service.

Requires Improvement

Is the service safe?

Our findings

The building was clean and looked well maintained. However, we noted that some items were inappropriately stored in communal areas and bathrooms. This meant that the service did not always look homely or welcoming. For example, a dry bucket and mops and a carpet cleaner were stored in a bathroom on the first floor. Continence pads were being stored in a toilet next to the lounge. Several mattresses were propped up in the corner of a corridor on the first floor. We also saw that cleaning products were stored in the pantry next to food. We asked the registered manager about this. They said, "We have no room for storage now. People keep bringing things in. The mattresses on the landing are there because some people are on pressure mattresses and we have nowhere to store the [regular] mattresses. The provider is in the process of doing up the outbuilding for storage and hopefully that will help. There is not enough room in people's bedrooms to store their continence pads."

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were assessed and the results were used to plan their support and care. Risks in areas including mental and physical health, personal risk (including dressing and walking), pressure sores and nutrition were undertaken and then reviewed on a monthly basis. Where the risk to a person had changed, this was recorded and used to develop the care plan to address it. For example, we saw that one person was recorded as being at increased risk of malnutrition due to living with dementia. The care plan had been updated and noted the requirement to provide more prompting and encouragement with meals, and we saw that this was done at lunchtime. In another assessment, we saw that a nutritional risk assessment had identified that a person's nutritional intake should be recorded so that their risk of malnutrition could be monitored. We saw that this was being done, which helped reduce the risk to that person.

People also had individual risk assessments where specific risks arose. For example, one person had a 'flooding [their] bedroom' risk assessment as they liked to wash and groom themselves in their bedroom. The plan recorded the person sometimes forgot to turn the tap off, so the risk assessment led to the plug being removed from the sink and discreet staff checks to reduce the risk of flooding. This meant that risks to people's health and wellbeing were assessed and steps to reduce them were taken.

A number of checks were carried out around the service to ensure it was safe for people to live in. A health and safety audit had been carried out by an external company in April 2015. This identified some areas to be addressed, and the registered manager showed us that these had been done. Specific risk assessments, with risk reducing guidance, were in place for areas such as use of hoists, infection control and the use of bedrails.

Required certificates in areas such as PAT electricity testing, hoist tests, gas safety and fire detection and firefighting equipment were up to date. A comprehensive fire inspection was undertaken in 2007, which was annually reviewed by the registered manager to see if any changes had occurred. Checks of emergency lighting, firefighting equipment and fire alarms were undertaken. This meant that potential risks to people's

safety in the premises were assessed, managed and reviewed.

Each person's care plan contained an individual 'fire risk assessment'. This contained details of their comprehension of risk and emergencies and their specific support needs. These ranged from needing reminders about fire risk procedures through to needing the assistance of staff to leave the building. We asked the registered manager how this information would be given to the emergency services in the case of an emergency evacuation. They said they would collect the information into a single file which could be handed to the emergency services following our inspection. There was a business continuity plan in place, which had last been reviewed in May 2015. This included details of appropriate evacuation sites, staff emergency contact details and GP and relatives' details. This meant that people would receive appropriate support in emergency situations.

People were supported to access their medicines safely. Medicines were kept in a clean and secure room at an appropriate temperature. A medicines record book contained an entry for each person using the service. This had a photograph of the person, a list of their medicines, dates that they were received at the service, when it was administered to the person and the balance remaining. Details of any allergies the person had or any special instructions were also recorded.

There was a controlled drugs register in place to appropriately record their use, though no one at the service was using controlled drugs at the time of the inspection. Controlled drugs are medicines that are liable to abuse. There was a separate book to record details of people's 'when required' medicines, including details of when it was administered. However, we observed that records did not contain any guidance to staff on when people who could not communicate effectively might need their 'when required' medicine. We recommended that the service follow National Institute for Health and Care Excellence guidance in assessing and recording how staff could recognise when people who had difficulty communicating needed their 'when required' medicine.

We looked at four medicine administration records ('MARs'). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. These had been fully completed and signed by administering staff, which meant it was possible to see when people had received their medicines. The MARs also recorded any changes in a person's medicines. For example, we saw that one person had been prescribed a short course of medicines and this had been fully recorded on their MAR.

We observed a medicines round. People were supported in a kind and patient manner. Staff explained to people which medicine they were being given and what it was for. Where a person did not want their medicine, staff waited for a short time before coming back to ask them again. This meant that the service had procedures in place to support people to access their medicines when they needed them.

The service had policies and procedures in place to reduce the risk of abuse occurring. Safeguarding and whistleblowing policies were in place, which contained details of the types of abuse that staff should look out for and the policy to be followed if they had concerns. Staff received safeguarding training and had a good working knowledge of safeguarding issues. One said, "I have got safeguarding training tomorrow and have also done some as part of my Care Certificate training. I would go straight to the manager or the senior with any concerns." Another said, "I look out for any kind of abuse, including financial, physical and things like that. If I had any concerns I would go straight to the manager or go higher if need be. We have a whistleblowing policy and I would be confident to use it." The last safeguarding incident occurred in September 2014, and the registered manager explained that this had been dealt with in an appropriate way. They said, "If I ever have any doubts I phone [local authority] safeguarding for advice." This meant that the risk of abuse of people was reduced.

Procedures were in place to ensure that only appropriate staff were employed. Applicants filled in an application form which asked about their knowledge of the care sector and any relevant experience. Two references were obtained, including (where possible) from current employed. Staff underwent a Disclosure and Barring Service (DBS) check before they started work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Staff confirmed that they had been through this process. One said, "I had a DBS check and needed two references from my last employers. I had to wait for the checks to come through before I started". This reduced the risk of people being cared for by unsuitable staff.

Staffing levels were determined by the registered manager, who said they were based on people's levels of dependency. They said, "I don't have [a tool] to do staffing levels. I brought someone extra in to cover the tea period so that I didn't have to take staff off to do it. If needs change we just bring people in. The provider leaves it to me, for example we recently had someone on end of life care and I brought someone extra in to help with that." Day staffing (during the week and at weekends) levels were a senior carer and two carers working from 8am to 2.30pm, and the same from 2.30pm to 9pm. Night staffing levels (during the week and at weekends) were a senior carer and carer working from 9pm to 8am. Staff rotas confirmed those staffing levels. Staff told us there were enough staff to support people. One said, "I think we have enough staff. We manage during the day and all get into a rhythm. I think there are enough on both morning and late shifts." Another said, "I think there are enough staff. I have done days and some nights and there are enough staff on both. There are busy days but then there are days when we are quiet. People are helped quickly if they need it." During the inspection call bells were answered quickly, and we saw that people were supported promptly and with patience.

Requires Improvement

Is the service effective?

Our findings

Staff received the training they needed to support people effectively. This included mandatory training and refresher training in areas such as moving and handling, first aid, health and safety and safeguarding. Mandatory training is training that the provider thinks is necessary to support people safely. We looked at the training matrix, which is a document used by management to monitor the training staff have completed. The training matrix showed that most mandatory training was up to date, with staff having either completed training or with training arranged. However, the training matrix also showed that some staff had not completed mandatory training and no training was arranged for them. For example, some staff had not received refresher training in medication awareness since 2007. The registered manager said, "I have a matrix [to monitor staff training]… It is every three years for refresher training. I use the Tyne and Wear Care Alliance for training. [Some staff] need updated training and are booked in. I am waiting for places from the Alliance. We have also done some extra training, for example the dietician has given them training." We recommended that the service follow National Institute for Health and Care Excellence guidance on reviewing and arranging medicines training for staff.

Staff told us that they received enough training to carry out their roles. One said, "I think the training is enough." Another said, "We're always on training. It's useful to help us do what we need to." Staff told us that they would be confident to request additional training if they thought they needed it, and were sure it would be arranged. A visiting relative said, "I definitely think they have enough training here. They always use equipment when they are supporting [my relative]."

Newly recruited staff received induction training to ensure that they had the skills needed to support people. This covered areas such as health and safety, fire safety, accidents, safeguarding and moving and handling. Staff files we looked at confirmed that this training had been completed. One member of staff said, "When I first started I was just shadowing. In my first week a senior carer observed what I was doing. I then had a sit down with the registered manager after a month to see how it was going. I learnt a lot from my [induction] training, especially on dementia."

Staff received supervisions and appraisals to assist them with their professional development. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Records in staff files showed that staff discussed their strengths and weaknesses, awareness of policies and any additional training needs they thought they had. Some supervisions took the form of staff being monitored supporting people and having their skills assessed. For example, we saw that one member of staff had been assessed helping a person to mobilise. This meant that the service was monitoring staff competency and knowledge in the delivery of their roles.

People were supported to maintain a healthy, personalised diet. A daily menu was displayed in the dining room, and people were asked throughout the morning what they would like for lunch that day. We saw that they were asked again when they sat down in case they had changed their mind. The cook was able to describe people's dietary preferences and where people were on specialised diets such as diabetic or soft foods, and we saw that people received the appropriate meal for them. Most people chose to eat in the

dining room, which had a friendly and relaxed atmosphere. One person changed their mind about what they wanted for lunch when it arrived, and a replacement of their choice was quickly arranged. One person said, "They'll give you anything you like here." Where appropriate, the service monitored people's weights and we saw an audit of this process from the local NHS trust dated February 2015. It read, 'The Branches…make sure that they screen their residents monthly for their risk of malnutrition…They also make sure all residents weights…are documented each month'. We saw that monthly weights took place and individual MUST charts were completed for people to monitor their health. This meant that the service monitored people's nutritional health.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. People's care records contained details of their mental capacity, any DoLS authorisation in place and the date that it expired. We saw that applications for DoLS renewals were submitted in advance of the expiry date, which meant that the service ensured that people were not being illegally deprived of their liberty. Where applications were made they were supported with evidence of a 'best interests' assessment. 'Best interests' is where staff seek to make decisions on people's behalf in order to keep them safe or otherwise in their best interests. Staff had a good working knowledge of the principles of the MCA. One member of staff said, "If people haven't got capacity… family members and others would get involved. If people [are living with dementia] we ask them and if they don't understand we leave it for a bit and ask them again. It may be that they have changed their mind or have made a decision." Another said, "We have done capacity training. We would document any changes and would seek an assessment [if we had any concerns]. We always ask people for consent." This meant that the service protected people's rights when they lacked mental capacity and could not make decisions for themselves.

The service supported people to access external services to maintain and enhance their health and wellbeing. People's care records showed that their health was reviewed by GPs, and that there was input from specialist services such as the diabetes and MUST clinics needed. The service had links with the local NHS trust to support people with their nutritional needs. The service was also using a 'nursing home protocol' devised by the local GP surgery in an attempt to reduce hospital admissions. This meant that people were supported to maintain their overall health and wellbeing.

Good

Is the service caring?

Our findings

People were treated with dignity and respect. Throughout the inspection we saw that where people indicated that they needed assistance staff approached them and asked them discretely how they could help. Where people were in communal areas such as the lounge and asked to speak with staff about help they needed, we saw that staff walked with them to quieter parts of the building to discuss it. Doors were closed if personal care was being delivered, and staff knocked and asked for permission before entering people's rooms. Staff understood the importance of maintaining people's dignity and privacy. One said, "We ask people if it's alright to help and do things like cover people with towels and close doors." Another said, "I always cover people with a towel when I'm working with them." This helped to maintain people's privacy and dignity.

Staff tried to maintain people's independence when supporting them. For example, where people were supported with their food, staff asked how much help the person would like and gave them the opportunity of carrying out tasks for themselves at every point. We saw that people responded positively to this, and were maintaining their independence with the support and encouragement of staff.

Staff interacted with people in a friendly and caring way. As they moved around the building they made an effort to chat with people, and in doing so we saw that they were able to recognise when people might need assistance. People obviously enjoyed talking to staff, and at several points during the inspection we saw staff sitting in the lounge talking with them. One person asked for Christmas music to be played, and this led to a sing along with people and staff. The registered manager was regularly checking on people in the lounge and other areas, and joined in the singing.

Staff valued the time they spent with people. One said, "We get to know people by talking to them and giving them time to answer. We ask them about when they were younger and if they were married." Staff tailored their communication style to the person they were supporting, for example speaking loudly around those who were hard of hearing and using short sentences and speaking slowly with people living with dementia. One member of staff said, "We use different approaches with different people. For example, we always explain what we're doing in detail to those who can't see well."

Staff clearly knew people well and they were able to discuss their families and backgrounds with them. For example, when one person had a relative visit staff discussed their Christmas plans with them. When another person returned from a meal with their family, we saw staff joking with the person and their relatives. A visiting relative said, "…all of the [staff] are lovely. I've seen a bad home and I know how good this is."

People were assisted to access advocacy services. Advocates help to ensure that people's views and preferences are heard. The registered manager said, "We have four people who have help from [advocates]. Staff would come and speak to me if they thought someone needed an advocate. We have [advocate] visits every four to six weeks." Care plans recorded if a person was receiving support from an advocate. This meant that there were procedures in place for ensuring that people's voices were heard.

Good

Is the service responsive?

Our findings

Care was planned and delivered based on people's assessed needs and preferences. Some care plans contained a detailed life history of the person, and a summary of their needs and preferences. The registered manager told us that they were in the process of introducing summary sheets for everyone living at the service, which would allow staff who had not supported them before to easily familiarise themselves with the person before meeting them.

People had individual care plans covering personal care, continence, communication, social stimulation, mobility, pressure area care, and DoLS. Each plan had an identified need, the desired outcome and the action to be taken to help achieve it. For example, one person had a desired outcome in their pressure area care plan and a number of actions were listed to achieve it, including use of a pressure relieving mattress, a cushion in their chair and visits by the district nurse. We checked and saw that these were in place, which meant that the person was getting the care they needed. Care plans recognised people's individual needs surrounding care delivery. For example, one person's plan read, 'Requires reassurance from carers when assisting [person] with personal care.' This meant that care and support was delivered in the way that people wanted it.

People's care plans were reviewed to ensure that they still met people's needs and preferences. For example, we saw that one review took place involving the person, the registered manager and a carer. Input was sought from everyone present and deterioration in the person's health was identified. It was agreed to seek a referral to the older person's mental health team for further advice. A visiting relative told us, "We were involved with the care planning, especially at the beginning. I was asked my opinion." This meant that people were involved in their own care planning which helped to ensure it responded to their needs.

Activities were organised for people living at the service. A member of staff told us that staff were responsible for organising and running these, and that they took place every afternoon. A weekly activity planner was displayed in the lounge area which included games, exercises and quizzes. During the inspection we saw people engaged in singing with each other and staff, which they appeared to enjoy. One member of staff said, "We do activities in the afternoon. Some people enjoy it, some don't. There is usually something that people will enjoy." Another said, "We try to get [people] involved. We discuss what they would like to do at residents' meetings and people have enough to do." A visiting relative said, "I can't fault them in here. [They're always] socialising." A record was kept of activities that had taken place and who had attended, and staff told us that this helped them to plan future activities. This meant that there were procedures in place to assess whether people had access to activities and to tailor them to their preferences.

The service had a complaints policy, which was advertised in the reception area. This set out how people could complain, how it would be investigated and timeframes for actions to be completed. The last complaint logged was in June 2015, and there was evidence that the matter was investigated and the person involved was satisfied with the outcome. A visiting relative said, "If I had any issues I would come straight to [the registered manager]." This meant that people knew how to complain, and that the service had procedures in place to deal with them.

Requires Improvement

Is the service well-led?

Our findings

The registered manager said they carried out a number of checks to monitor and improve standards at the service. They said, "I do care plan audits, medicines, daily reports, check the handover books, the cleaning rotas, the kitchen temperatures and checks…[and] an annual check of opinion through questionnaires." We asked to see the records of these checks. The registered manager said that they did not keep records, and would deal with any issues identified in the checks as they arose. We asked how the registered manager monitored and addressed any patterns that might arise in audits, and they said that they would keep records in future. They said that the provider had just invested in a new quality assurance computer system, which would keep records of audits. Our judgement was that the audits currently undertaken were not fit for purpose as they did not allow the registered manager or provider to access all necessary information when needed and we could not see how the results were used to monitor or improve standards.

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

The service sent people an annual questionnaire asking them for their views, and kept the responses from this. We looked at some of the responses to the most recent survey in January 2015, and saw that these were positive. One person, who filled the questionnaire in with the help of a relative said, '…can't fault the care, meals or staff…[person] is happy with everything' and had no complaints or changes recorded. This meant that people's feedback was used to monitor standards at the service.

Questionnaires were also sent to external professionals who worked with the service to obtain their views on any improvements that could be made. A district nurse said in a questionnaire dated April 2015, 'Over many years I have been happy to professionally visit The Branches. At all times staff are helpful and supportive. They show a high level of expertise in the care of their residents. Residents are very well cared for. High standards. Very homely. Excellent management. Well-led.' Another district nurse completed a questionnaire in February 2015, and said, 'There is evidence that staff promote self-help, equal opportunities, motivation, mobility and choice…Staff are really friendly and caring. The Branches is a lovely, warm and welcoming home and residents are extremely well-cared for.' This meant that external professionals' feedback was used to monitor standards at the service.

We asked staff to tell us about the culture and values of the service. One said, "I think we look after people better than the big homes. I think we do it better as we give people proper care. It's homely, all like a big family. It's like having 20 or so nanas and grandads." Another said, "It's such a homely place. All the residents are lovely. Staff are caring and friendly and the manager is lovely as well. I enjoy working here. It's so rewarding, I just love it."

Staff told us that they felt supported by the registered manager and provider. One said, "[The registered manager] is definitely approachable. I have seen [the provider], who comes in a couple of times a week." Another said, "I can't fault [the registered manager] or [the provider]. [The provider] is in quite regularly and helps out with anything, like cleaning carpets or putting lightbulbs in. [The provider] talks to the clients. [The

registered manager] is approachable and really good, helps in any way they can." A third member of staff said, "[The registered manager] is very approachable. I would go and see them with any problems." This meant that staff felt the service was well-led.

The registered manager felt supported by the provider. They said, "I've got a lot of leeway with the provider. If I think we need anything I put it to them and usually we get the go. For example, we have just ordered some new tables and chairs for the dining room and new laundry equipment." They added, "The provider leaves checks to me. If they come in and saw something they weren't happy about they would come and ask me." The registered manager went on to say, "I don't get supervisions and appraisals but I know a lot of managers from other homes [for support]. I also get a lot of support from the Tyne and Wear Care Alliance, so I don't feel isolated." The registered manager understood the responsibilities of their role. We noted that all relevant notifications concerning the service had been made to the Commission.

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	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises were not being properly used as items were inappropriately stored in communal and food storage areas in a potentially hazardous way. Regulation 15(1)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Checks and audits by the registered manager were not fit for purpose as there were no records kept which meant they did not allow the registered manager or provider to access all necessary information when needed and we could not see how the results were used to monitor or improve standards. Regulation 17(2)(a).