# Bafford House Residential Care Home

# Bafford House

## 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? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

We inspected Bafford House on the 29 and 30 September 2016. Bafford House is a residential and nursing home for up to 19 older people. Many of these people were living with dementia. 17 people were living at the home at the time of our inspection. This was an unannounced inspection.

We last inspected in August 2015 and found that the provider was not meeting a number of the regulations. We found that people did not consistently receive safe care and treatment, because an assessment of their care needs had not always been written or maintained. Additionally staff did not always have access to the training and support which they required. The registered manager did not have effective systems to monitor and improve the quality of service people received and did not always notify us of notifiable events within the service. Staff did not always ensure people were protected from harm or identify if they had capacity to consent to their care. People did not always receive the support they needed to meet their nutritional needs. Following our inspection in August 2015, the provider provided us with a plan of their actions to meet the fundamental standards. However, during this inspection we found while some improvements had been made the service was not meeting a number of the fundamental standards.

At our inspection on 29 and 30 September 2016, 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.

The provider did not have effective systems to monitor the quality of service people received. Audits were not consistently carried out and did not address shortfalls in the quality of the service to drive improvements. There was no evidence that people and their relative's views had been sought or acted on.

There were enough staff deployed to meet people's day to day needs. However, there was a high level of agency staff working at the service who did not always know people's needs when they started working at the home, There was a consistent management team in place who were managing the staffing levels, by recruiting staff.

People mostly received their medicines as prescribed at times. Where people could receive their medicines covertly, there was no clear guidance for staff to follow on how to ensure people received these prescribed medicines.

People were at risk of unsafe care and treatment as assessments of their needs had not always been completed. People's care plans did not always reflect their needs or provide care staff with clear guidance to follow. People did not always receive care which was personalised to their individual needs.

People we spoke with were positive about the home. They felt safe and looked after. People enjoyed the

food they received in the home and had access to food and drink.  People did not always benefit from meaningful engagement from staff. Records did not always show if people had been involved or enjoyed activities and external entertainment.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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. The provider had not acted on requirements made following the last inspection and the service. The risks of people's care had not always been effectively assessed and recorded. Care staff did not always have clear guidance on how to meet people's needs. Where people could have their prescribed medicines administered covertly, there was no clear care plan in relation to this need.

People could not be assured they would be safe in the event of a fire. There was a potential risk to people living in the home as safety checks were not carried out regularly.

Staff were deployed within the service to ensure the safety of people and protect them from risk. There was a high level of agency staff working at the service who did not always know people's needs when they started working at the home, There was a consistent management team in place who were managing staffing, by recruiting staff.

People felt safe, and staff understood their responsibilities to protect people from abuse. People's prescribed medicines were managed well.

### Is the service effective?

**Requires Improvement**

The service was not always effective. People were supported by staff who did not always have access to the support they needed to meet people's needs.

People were support to make day to day choices, however there was not always a clear record that their ability to consent to their care had been recorded.

People received support to meet their nutritional needs and had access to plenty of food and drink. Staff were trained to carry out their role.

People were supported with their healthcare needs. Staff followed the guidance of external healthcare professionals. Healthcare professionals spoke positively about the service.

## Is the service caring?

Good

The service was caring. People were supported to spend their days as they choose. Staff respected people and treated them as equals.

Staff mostly knew people well and understood what was important to them such as their likes and dislikes. People were treated with dignity and respect.

## Is the service responsive?

Requires Improvement

The service was not always responsive. People's care assessments were not always current or accurate. People did not always receive their care in a way which was in accordance with their personalised needs.

People had access to activities however this was often dependent on staff deployed within the service. There was limited evidence or records of the activities and interactions people received.

The registered manager told us they responded to complaints and concerns. People and their relatives felt confident they could raise concerns to staff.

## Is the service well-led?

Requires Improvement

The service was not well-led. The provider had not acted on requirements made following the last inspection and the service.

There were not effective and consistent systems in place to monitor the quality of the service people received. Audits had not been consistently carried out within the service. There was no record that people or their relative's views had been sought.

Agency staff did not always feel they received information which would enable them to meet people's needs.

There was a consistent management team in place managing the service on a day to day basis.

# Bafford House

**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 was 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 the 29 and 30 September 2016 and was unannounced. The inspection team consisted of one inspector.

At the time of the inspection there were 17 people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We also spoke with two healthcare professionals and local authority commissioners about the service.

We spoke with seven people who were using the service and with three people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four care staff, the deputy manager, the registered manager and providers (one of whom was the registered manager). We reviewed seven people's care files, care staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection in August 2015, we found that staff did not always ensure people were kept safe as processes to learn from incidents and raise concerns were not followed. People were at risk of unsafe care and treatment as an accurate record of their care and risks had not always been assessed or maintained. People were at risk of not receiving their prescribed medicines as clear guidance around covert medicines were not in place. We also found that the service had not continually reviewed the amount of staff deployed to meet people's needs. These concerns were a breach of regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action. They sent us an action plan which stated they would meet the regulations in full by the end of August 2016. At this inspection we found the provider had taken action to ensure staff learned from incidents and accidents to protect people from harm. However people were still being placed at risk of unsafe care and treatment as an assessment of their needs and the associated risks had not been maintained.

People's needs were not always effectively assessed and documented. For example, one person was staying at Bafford House for a period of respite. While a brief initial assessment of the person's needs had been documented prior to their admission to the service, there was no care plans or risk assessments in relation to their day to day care needs. During their time at Bafford House, this person had attempted to leave the home, which would have put them at risk. There was no assessment in place to guide staff on how to protect this person or meet their day to day care needs.

People were not always protected from the risks associated with their care as there was not always clear guidance for care staff to follow. For example, two people were being cared for in bed and were at risk of pressure ulcers. Both people's care assessments in relation to their skin integrity stated they needed repositioning regularly. We asked three members of care staff how often one person needed to be repositioned. Each member of staff provided a different answer of two, three and four hours respectively. We discussed this concern with the registered manager who told us they person should be supported to reposition every two hours.

Additionally there were no records kept by care staff of when each person had been repositioned. One agency member of staff had raised concerns prior to our inspection about one person having an area of sore skin. There was no record of the support the person received to address this concern, and the person's care plan had not been updated to reflect this risk.

One person's GP had agreed their prescribed medicines could be administered covertly when the person refused two of their prescribed medicines. This approval had been recorded in the person's care file. On four days prior to our inspection the person had refused one of their prescribed medicines. Care staff informed us they had not administered this person's prescribed medicines covertly, and did not know when the person should be given their prescribed medicines covertly. This meant the person was at risk of not receiving their medicines as prescribed and agreed with their GP.

The above concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People could not be assured the premises were safe, as regular safety checks of the premises had not always been carried out in accordance with the provider's policies. Fire safety records showed not all safety checks and procedures were carried out regularly. For example, there was no record of fire safety drills or weekly fire exit and extinguisher checks. Fire extinguishers within the building had not been serviced since May 2015 and were overdue for their annual service.

People's safety could be placed at risk as there was not always a safe escape route from the home in the event of a fire. For example, three doors on three individual fire exit routes were secured by keypads. These keypads were not linked to the home's fire alarm system which means the doors would remain locked in the event of a fire alarm. Additionally one of these doors had recently been painted which meant it was difficult to open and close. Another fire exit door had warped and was no longer shutting properly. We raised the concerns about people's safety with the registered manager and provider who told us they would take action to rectify these concerns.

The above concerns were a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were stored in accordance with manufacturer's guidelines. Care staff recorded the temperature of the room medicines were stored in. These recordings showed the temperatures were within the recommended range of the manufacturer. People's prescribed medicines were stored securely. This meant the risk of people's prescribed medicines being inappropriately used was reduced. Care staff kept a clear record of the support they provided people regarding their prescribed medicines. People's prescribed medicines were checked when they were delivered to the home by the pharmacy. This reduced the risk of people from mismanagement of their prescribed medicines.

People and their relatives were happy there was enough staff deployed on a daily basis to meet people's needs. Comments included: "There is always someone around"; "I don't have to wait if I need someone to help" and "Sometimes they're busy, however they have time for me."

Staff told us there was enough staff deployed to meet people's needs. Comments included: "Four members of staff is just right, gives people stimulation. Everyone gets their needs met" and "We get enough time with the residents."

Permanent staff raised concerns regarding the high use of agency staff and the impact it had on them. One staff member said, "It's a bit stressful. It can be difficult working with agency. Fortunately we are getting the same agency staff, people know them. "For example one member of staff told us how they had to support agency staff to meet people's care needs; They explained that as many people were living with dementia, agency were unfamiliar with people and required more guidance.

The registered manager openly discussed the high use of agency in the home was needed to ensure people's day to day needs were met. They explained they were actively recruiting new care staff. They told us they booked regular agency care staff, to ensure there were enough staff deployed who were familiar to people living at Bafford House whilst they recruited more permanent care staff. The registered manager informed us two care staff were in the process of being recruited. At this inspection we did not check recruitment records for care staff, as no new care staff had been employed since our last inspection in August 2015.

People told us they felt the home was safe. Comments included: "I feel safe here"; "I feel safe, definitely" and "Oh I think I am safe here." One relative told us, "I don't have any concerns about them being safe."

People were protected from the risk of abuse. Care staff had knowledge of types of abuse, signs of possible abuse which included neglect, and understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the registered manager, or the provider. One staff member said, "I would report it to the manager and record that." Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to local authority safeguarding or the CQC. They said, "If something hasn't been done (about the concerns) I would call (local authority) safeguarding". Agency staff confirmed they would also go to their line manager if they had any concerns regarding people's safety.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in August 2015, we found that staff did not always have the skills they needed to meet the needs of people living at Bafford House. Additionally people's ability to consent to their care had not always been recorded and people were not always supported to meet their nutritional needs. These concerns were a breach of regulation 18, 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 respectively. We asked the provider to take action regarding this concern. The provider gave us an action plan which stated they would meet the relevant regulation by the end of August 2016. At this inspection we found that staff had been trained and people's nutritional needs were being met however people's consent to care had not always been sought.

People living at Bafford House were living with dementia and a number had varying mental capacity to make specific decisions regarding their care. Their capacity to consent and make decisions was not always being assessed and documented appropriately. There were not always mental capacity assessments documenting individual people's ability to consent to their care or around specific decisions in relation to their care. For example, one person's GP had authorised the use of covert medicines. There was no documented care plan with regard to a best interest decision being made for the person being administered their medicines covertly.

Another person had been deemed by the service as not to have capacity to understand the risks to their safety if they left the premises unsupervised. The provider and registered manager had made an application to Deprivation of Liberty Safeguard (DoLS) authority for this person. There was however no mental capacity assessments carried out by the provider in relation to this person, specific decisions and decisions the person can make on a day to day basis. 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).

The above concerns were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent and agreement was asked for by care staff before they delivered their care. We observed on many occasions staff asking people if they were happy for to be supported with specific tasks. For example, care staff asked people if they needed assistance with their personal care or help them to eat. Care staff (including agency staff) were aware of the Mental Capacity Act 2005 and the principles that underpin this. 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. One staff member told us, "It all depends on the person and the decision they need to make. We can never assume they can't make a decision. We try and explain and encourage, see if they can understand and make an informed decision." Another staff member said, "I always offer people choice, enable people to make decisions where they can."

People were supported by staff who had access to the training they needed to meet people's needs. People and their relatives felt staff had the training and skills they needed to carry out their role. Comments included: "The staff are a good crowd, they really do help"; "They are doing a good job here"; "The staff are nice and helpful. I've got to know them." Healthcare professionals spoke positively about the senior staff in the home and their skills. One healthcare professional told us, "They really look after patients well."

Staff employed by the provider told us they had access to the training they needed. One member of staff said, "Plenty of access to all training. I've wanted more dementia training and I'm going on the dementia leadership award. This will help." Another member of staff told us, "At this point yes (I do have the training I need).It (training) really helps." The service's training records showed staff employed by the provider had accomplished the training that the provider would expect them to complete. Where training was due to be refreshed the provider had plans to ensure staff had access to this training they needed to meet people's needs.

People were supported by staff who were encouraged to develop professionally. One member of staff spoke positively about completing a qualification in dementia care. They told us, "I'm trying to finish my NVQ 3 (national qualification). They've (provider and registered manager) been supportive. If I have to have time with my tutor, I can have it. My NVQ focuses on dementia, it really helps" and "The registered manager and provider are encouraging development, to make things better."

People were cared for by staff who felt supported informally but not formally. Care staff employed by the provider told us they could openly discuss concerns and felt incredibly supported by the registered manager and provider. One member of staff said, "I get plenty of support." However, care staff told us they did not always receive regular supervision (one to one meetings) or an appraisal from their line manager. One member of staff when asked if they had regular supervision told us, "Not as regularly as we should do. I would like them more frequently." The provider and registered manager were aware that some staff had not always received regular documented supervision, and would take action to remedy this.

We recommend the provider and registered manager review their annual appraisal and supervision processes to ensure all care staff have access to continuous supervision.

People told us they enjoyed their food. Comments included: "Very good food, we get sufficient variety", "The food is good, I had a very nice lunch" and "good food and drink here."

Since our last inspection the provider had ensured people had access to the nutritional support they needed. On both days of our inspection a member of the provider management team was running the kitchen. They knew people's dietary needs, including people who required a diabetic diet or their foods pureed. Most of the people living at the home chose to go to the dining room for lunch where there was a pleasant atmosphere. Food was generally well presented and care staff (including agency staff) aware of people's dietary needs. One person required a soft diet, and their food was clearly presented in a way in which the person could identify the different colours and flavours. We were told that the provider was recruiting a chef who had previously worked in the home.

People's individual dietary needs were met. For example, care staff had identified one person who had a very poor appetite and often chose not to have meals. The provider and registered manager had sought dietary support for the person and was providing them with supplementary and fortified drinks (high calorie) to ensure the person's nutritional needs were being maintained.

People had access to health and social care professionals. Records confirmed people had access to a GP,

dentist and an optician and could attend appointments when required. People's care records showed relevant health and social care professionals were involved with people's care. For example, feedback from appointment was recorded and followed. Two healthcare professionals spoke positively about the service. They said, "They (registered manager and provider) make very appropriate referrals. If a plan is put in place it happens."

Good

# Is the service caring?

## Our findings

People and their relatives had positive views on the caring nature of care staff. Comments included: "I'm happy here"; "It's a nice small home, I don't have any concerns"; "It's very nice here, I like it very much, Lots of happy faces. I can't think of anyone that isn't nice" and "It's a good care home."

Care staff often interacted with people in a kind and compassionate manner. Care staff adapted their approach and related with people according to their communication needs. For example, one person struggled to communicate verbally. A staff member slowly talked to the person at eye level, which enabled the person to see their face. The staff member looked at the person's body language to ensure the person was comfortable and to enable them to identify if the person was happy when they offered them a choice.

Staff spoke to people as an equal and supported them to maintain their independence. For example, we observed a member of staff assisting someone with their mobility. The person was walking with equipment and the member of staff stood with them and slowly encouraged them to move to the home's lounge. The person was support to choose where they wanted to sit in the room and their choice was respected.

Most care staff knew the people they cared for, including their likes and dislikes. When we discussed people and their needs with staff, most staff confidently spoke about them. For example, one care staff member was able to tell us about one person, including how they liked to spend their days and the things which were important to them. They told us how the person liked to go into the local town centre and enjoyed living an active and busy life.

People were able to personalise their bedrooms. One person had items in their bedroom such as pictures of people who were important to them. Staff respected the importance of people's bedrooms. They ensured people's bedrooms were kept clean and knocked on bedroom doors before entering.

People were treated with dignity and respect. We observed care staff assisting people throughout the day. One person was anxious and tearful during the morning. Care staff worked quickly to ensure the person was comfortable and spent time with them in the privacy of their room to help reassure them. Where people were receiving personal care, staff ensured their bedroom doors and curtains were shut. Care staff told us how they respected people's dignity. One member of staff told us, "I would never leave anyone exposed. I would use towels to make sure they were comfortable and warm."

People enjoyed friendly relationships with care staff. One staff member agreed to sit and read a book with a person. During the afternoon the member of staff sat with the person and started reading the book, they both enjoyed a lively conversation about the book and the person enjoyed having the time with the member of staff.

Requires Improvement

# Is the service responsive?

## Our findings

The care and support people received was not always personalised to their physical needs. All of the people living at Bafford House were having aspects of their care and treatment recorded such as their food and fluid intake and personal hygiene support requirements even though individual risks or therapeutic needs for this monitoring had not always been identified. Where staff were monitoring people's fluid intake they did not always understand the purpose for this or how much each individual person needed to drink. One member of staff told us, "Everyone is on fluid charts." When asked if they knew why or how much each person needed to drink, they were unsure.

There was no clear purpose for why monitoring information was recorded or how this information was used to identify any concerns about people's welfare. Some people had people's individual monitoring charts such as bowel charts however they were inconsistently completed. Their care plans did not identify why these records were in place. We discussed these concerns with the registered manager and provider, who informed us they would review their monitoring procedures and ensure staff had the correct information they needed.

People were not always in receipt of person centred care. For example, one person asked for a cup of tea. A member of agency staff stated that tea would be around later in the day, and did not act on the person's request. We discussed this observation with the registered manager and provider who informed us they would ensure all staff respect people's request for food and fluids.

The service was often reliant on agency staff to provide activities. There was a limited record of the activities people received. On the morning of our inspection, there was no member of staff available to engage and provide activities for people. We observed that people went without engagement for long periods of time, such as 30 minutes. Staff told us when staffing was slightly short it meant people didn't have access to activities outside of personal care, unless an external entertainer was visiting the home. One member of staff said, "We're one short this morning, however we manage everything. When we're short activities are at risk."

The above concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not always reflect changes in their needs and did not give care staff guidance on meeting these needs. For example, care staff had identified one person was often anxious and exhibited behaviours which challenge. Whilst this had been recorded, their care plan had not been amended to reflect this change or the support care staff provided or needed to provide. Guidance was not documented on how this person should be supported to reassure them and protect them and other people from harm. Another person's care plan did not reflect changes in their wellbeing and the support they required. Staff had identified changes in the person's wellbeing and while this had been documented in on-going records, there was no clear guidance for care staff to follow to meet this person's needs.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

People told us they enjoyed living in Bafford House and felt there were offered things for them to do. Comments included: "We had skittles earlier. We enjoy it all. We like a bit of fun"; "Oh we're happy. We have music and singing which is good" and "We get time to sit and chat with staff. I don't feel bored." Care staff spoke positively about providing activities for people. One staff member said, "We have time to do things such as ball games, this really helps the residents too." Another staff member said, "I think it's nice. There is dancing with dementia here, which is so nice. Also manicures for the ladies which they enjoy."

On the afternoon of the first day of our inspection and during the second day, people enjoyed time spent with care staff. We observed care staff take time with people and carry out activities such as manicures and conversations. People and care staff told us they had just enjoyed ball games and skittles one afternoon of the inspection. People were happy and smiling following this activity session and were engaging with each other and staff.

People's relatives told us they were informed of any changes to their relative's needs or any incidents. One relative told us, "They ring me if there are any problems, and inform me of incidents. I am involved in care plans." People's care records showed where staff had contacted people's family to ensure their needs were being met.

Care staff took effective action when people's needs had changed. Healthcare professionals spoke positively about the management of the service and how staff reacted to people's needs. One healthcare professional told us, "They have a good insight into people's needs. They always have the correct and current information. They let us know when they need help."

The provider had a complaints policy. People and their relatives told us they knew who to contact if they had concerns around the service. Two people we spoke with told us they would tell the care staff or the registered manager if they were unhappy with the care they received. Since 2013 there had been no recorded complaints made to the service. The registered manager and provider told us concerns were handled as they were raised to ensure continuity of care.

Requires Improvement

# Is the service well-led?

## Our findings

When we last inspected the service in August 2015, we found the provider and registered manager did not have effective systems to monitor the quality of the service. The views of people, their relatives and staff were not always acted upon. This concern was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always notify us of incidents within the home. This concern was a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents. We asked the provider to take action regarding this concern. The provider gave us an action plan which stated they would meet the relevant regulation by the end of August 2016. At this inspection we found the registered manager/provider was notifying us of incidents within the home. However appropriate action had not been taken by the service to consistently implement effective systems to monitor the quality of the service.

People and their relative's views were not consistently sought or acted upon. The service had not actively sought and recorded the views and experiences of people who lived in the home since our last inspection. People's relatives, staff and health care professionals linked with the home had not been consulted about their experiences of Bafford House. The registered manager also did not keep a record of compliments they had received from people or their relatives. We discussed how the registered manager and provider sought people's views. They told us they did this informally. They told us surveys, resident meetings and relative meetings had not worked. The registered manager and provider told us they would ensure they sought people and their relative's feedback.

Since our last inspection the provider and registered manager had implemented systems to monitor the quality of service people received at Bafford House. However these systems were not always consistently used and did not always enable the provider and registered manager to identify concerns within the service. For example, care plan audits did not identify concerns around people's care plans being current and accurate and giving care staff clear information on people's needs. Additionally fire safety audits had not identified concerns with the home's fire doors and the servicing of fire extinguishers. Audits had not always been consistently used, due to a reduction in the number of permanent staff within the home, which meant the deputy manager was spending more time providing hands on care. At the time of our inspection the provider and registered manager had limited systems to ensure the quality of the service they provided.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Agency staff did not always feel they had the information they needed to meet people's needs when they started working at Bafford House. One staff member said, "I don't get everything I need. I asked for a handover one day and didn't get one for a while; this meant I didn't know things I perhaps needed to." The registered manager and provider were working on creating a short summary of people's needs which they were giving to agency staff. We were shown a copy of this information and one member of agency staff spoke positively about it. They told us "It helps us."

Healthcare professionals and agency staff praised the management of the service, including the deputy manager and a senior care worker. One staff member said, "The deputy manager and (senior care staff) were excellent." One healthcare professional told us, "They are easy to work with, easy to approach. The (registered manager and provider) are passionate about looking after patients and go out of the way to provide extra care. The management is consistent which helps."

The provider and registered manager notified the care quality commission of notifiable events. Where the service had raised safeguarding concerns, the provider had submitted the relevant notifications to the care quality 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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. Regulation 9 (1)(a)(b)(c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People who use services and lacked the capacity to consent were not protected by the MCA (2005) and DoLS. Regulation 11(2). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>People were not protected against the risks associated with unsafe or unsuitable premises because checks to ensure the property and fire systems were fit for purpose had not been carried out. Regulation 15 (1) (e). |

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were at risk of unsafe care and treatment because an accurate assessment of their needs and had not always been recorded or maintained. Regulation 12 (1) (2) (b). |

**The enforcement action we took:**

We have issued a warning notice to the provider that they must make improvements by 30 November 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems established to ensure compliance were not always operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The service did not maintain accurate, complete and contemporaneous record in respect of each service user Regulation 17 (1)(2)(a)(b)(c)(e)(f). |

**The enforcement action we took:**

We have issued a warning notice to the provider that they must make improvements by 31 December 2016.