Four Seasons Health Care (England) Limited

Westroyd Care Home

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 21 July 2015 and was unannounced. We returned on 22 July 2015 and this was announced. Our inspection took place following information of concern relating to poor staffing levels particularly during the night shifts.

Westroyd Care Home is registered to provide care for up to 66 people who require residential care without nursing. The home is split in to two units, the House and the Lodge. The House provides care to people who have residential needs whilst the Lodge provides care to people who live with dementia. Each unit provides care on two floors, had its own lounge and dining rooms. At the time of our inspection there were 57 people using the service.

The service does not have a registered manager. 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

Summary of findings

and associated Regulations about how the service is run. There was an interim manager on the day of our inspection who told us they had started the registration process to apply to be registered manager.

Inconsistencies in how the House and the Lodge were managed meant that people were not always kept safe.

Staffing levels had improved following a recruitment drive by the manager. Staffing levels were based upon people's dependency needs. The provider had taken appropriate action when people's needs had changed to ensure they were met. Staff recruitment procedures were robust and ensured that appropriate checks were carried out before staff started work.

Staff received appropriate and relevant training to support them in their roles. How staff implemented their learning was not consistent across the two units.

We found that people's capacity to consent to their care and treatment and others areas associated with their care had been considered, there had not been any decision specific capacity assessments carried out. Not all potential forms of restraint had been considered when creating care plans.

Inconsistencies were seen in how staff cared for people. Staff were task orientated in the House whereas in the Lodge they took time to support people in the way they needed.

Medicines were not managed consistently across the two units and there was potential for errors to occur. Medicines were safely stored but there were inconsistencies in the administration of 'as necessary' medicines.

People's needs were assessed and plans were in place to meet those needs. Risks to people's health and well-being were identified and plans were in place to manage those risks. People had their healthcare needs met by appropriate referrals to healthcare professionals. However care plans were complicated and it was not always clear where information was. The provider is introducing new care plans to make improvements in this area.

People's nutritional and dietary requirements had been assessed and a nutritionally balanced diet was provided.

There were systems in place to assess and monitor the quality of the service. This included gathering the views and opinions of people who used the service. Additionally, monitoring the quality of service provided the manager with information to learn from incidents and make improvements. People's complaints and issues of concern had been responded to promptly and appropriately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not consistently safe.

Staff were aware of the systems in place to report any concerns and understood their responsibilities.

Where risks were identified it was not always clear what action staff should take to minimise the risk.

Following recruitment staffing levels had improved.

Practices across the Lodge and the House were not consistent with regards to the management of medicines.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Staff had access to a variety of training to support them in meeting the needs of people who used the service. Staff also received regular supervision that looked at how to improve practice.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards were being met but some issues were identified about consistency in applying the legislation.

People had their nutritional needs met but people who lived in the House did not have regular access to drinks.

People were supported to see a healthcare professional when they needed to.

Is the service caring?

Requires improvement 

The service was not consistently caring.

The way staff treated people was not consistent across the two units. People who lived in the House were not always treated with dignity or respect.

The provider has introduced a service user representative to enable people to share their views of the service with the manager.

People and their families were encouraged to be involved in the development of their care plans.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Information in care plans was difficult to find and did not always match what care was being given.

Staff at the Lodge helped people who lived their engage in meaningful activities whereas staff in the House did not.

Summary of findings

The provider has a complaints procedure and where complaints are received these are investigated appropriately.	
Is the service well-led? The service was not consistently well-led. The two units were not managed consistently leading to different custom and practice in each unit. Staff knew how to raise concerns and felt confident that any concerns would be investigated by the manager. The provider has introduced systems to support the manager in their role; this includes daily meetings with head of departments and a new quality assurance questionnaire.	**Requires improvement** 

Westroyd Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether 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.'

The inspection took place on 21 July 2015 and was unannounced, we returned announced on 22 July 2105.

The inspection team consisted of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had expertise in understanding service for people with dementia.

Before our inspection we looked at information we held about the service and information we received from the local authority that paid for the care of some of the people using the service.

On the day of the inspection we spoke with 10 people who used the service, seven staff members, six visitors and one visiting healthcare professional. We spoke with area manager of the service, the interim manager, the unit manager at the Lodge, a senior care staff and three care staff. We also spoke with a health professional involved in providing healthcare to people who used the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care plans, three staff files and records associated with the management and running of the service. This included policies and procedures and records associated with quality assurance processes.

Requires improvement

Is the service safe?

Our findings

Due to anonymous concerns raised with CQC about the poor staffing levels we spoke with the interim manager regarding how staffing levels were managed. The manager told us that currently there was only one night senior over both the House and the Lodge as the other night senior handed their notice in. They told us that they were aware that this was not acceptable and were making efforts to recruit another senior care worker to cover the night shift.

We were shown applications of people the provider had recently recruited and new care staff were due to start work over the next few weeks following their recruitment checks. A member of care staff told us, "We do have enough staff now; it's got better over the last two to three weeks. The new manager has sorted that." Another member of care staff told us "We don't have any agency in the day now. We can have two out of the three at night as agency but I know the manager is recruiting."

We asked the manager how they worked out staffing levels for each unit. The manager told us they use a tool that worked out the staffing levels based on people's dependency needs. The manager told us and the area manager confirmed that they staffed the service above what the tool said as they were aware of the problems the use of agency staff had caused. This was confirmed when we looked at staff rotas. The manager always made sure at least one person was first aid trained on each shift and they always made sure that there was a mix of new and experienced staff.

We looked at people's care plans and they identified where people were at risk and what action staff should take to reduce risk. However this information was not always easily identified as it was often in review notes in the care plans. Care staff could not easily see what the risk was and how to reduce it. We discussed this with the interim manager who told us the provider was due to introduce new care plan paperwork and this would hopefully rectify this problem.

We looked at the medicines procedures across the two units and they were not consistent. The temperature of the room in the Lodge where medicines were stored were recorded but were outside of acceptable limits. We brought this to the manager's attention who told us they would make arrangements for a portable air conditioner unit to be purchased for the Lodge.

We looked at a sample medicine administration records from both units. We saw that photos were available of people and there were facilities to record any known allergies and GP details. However GP details were not always recorded in the House. The Lodge had recording mechanisms for the administration of creams which included a body chart to show where creams should be applied. The House did not use this system. Information in the records about when to apply cream was not consistent and records were not always clear as to whether the cream had been discontinued. We brought this to the manager's attention who made arrangements for changes to be made.

We found that the Lodge consistently recorded the receipt of medicines that came into the service but this was not consistent in the House.

In the House we saw medicine administration records used which were not in line with the rest and had been used since April 2015. The deputy manager said this was because the medicines were received from the mental health team, but acknowledged it should be recorded in the same way as the rest of medicines.

Information regarding the use of 'as necessary' medicines was not consistent between the two units and often relied on the care staff's knowledge of the person to know when to administer the medicines. This meant if staff did not know the person well or did not know the perimeter when they should be given it could lead to inconsistent practice.

We found that controlled drugs were stored appropriately and quantities were correct in both units including information regarding what was returned to the pharmacist.

Pharmacy audits had been conducted for both units in May 2015. A small number of recommendations were made and we were advised that these had all been actioned. However in the House we saw that it was recommended that products with a short shelf life and eye drops should be dated on opening. We saw that there was an open food supplement in the fridge not dated and that creams were not always dated on opening. This meant not all recommendations had been actioned.

On the second day of our visit we arrived at 8.55 am, the call bell started to ring on our arrival. We waited to see if anyone would respond. After 10 minutes we spoke with a staff member, who was administering medicines. They told

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Is the service safe?

us it was the call bell and to go and check the panel in the reception to find out where it was coming from. We went to the bedroom where the call bell system indicated a person was calling for aid. We heard shouting and on entering the bedroom found a person in a great deal of distress. The second inspector attempted to find care staff to assist this person but there were no staff around. By this time the person had become unstable on their legs and so the second inspector provided a chair and left the room.

We remained with the person providing reassurance until the manager, deputy manager and a carer arrived. The carer was speaking to the person in a raised voice although it was clear that this was not necessary. Their first priority did not seem to be reassuring the person, but was task focussed in getting the person to walk across the room.

We went to see a second person who had pressed their call bell. They said, "I get in a bit of a mess getting up. I called about an hour ago." We waited with the person until a staff member came. We spoke with this person later who told us they had just come into the home, but they didn't usually have to wait that long.

We discussed both incidents with the area manager and the interim manager as we were concerned that had we not been present to call for aid on behalf of these people they may have become more distressed and fallen. The area manager agreed that part of the problem was the call bell system was inadequate for the purposes of the service. During our visit arrangements were made to have a site visit from a company that installs call systems. Following the inspection the interim manager confirmed that arrangements for a new call bell system to be fitted had been made. The manager also told us that the incident we observed had been referred to safeguarding and supervision of the staff involved had taken place.

People we spoke with and their relatives all said they felt the service was safe. A person said, "I like it and obviously feel safe." Another person told us, "I feel safe, as the staff are excellent and food as well." A visitor said, "My [person using the service] has been here since October 2014 and I feel comfortable, as they suffer with Alzheimer's and are safe here." Another visitor told us, "My [person using the service] is safe here; as my other relatives do visit regularly, and all agree the care is good."

Staff told us they had received safeguarding training, they were able to describe different types of abuse and knew how to report any concerns both internally to the provider and externally to the local authority. We looked at training records and this confirmed that staff had access to safeguarding training.

The provider had robust systems in place that looked at any untoward incidents and what action had been taken to minimise future risk. The manager showed us examples of where this system had been used and what remedial action had been taken to reduce the risk.

Staff confirmed that they had medication training and six monthly competency checks. A care staff told us, "If there was an error I'd tell the manager and call 111 for professional advice."

We saw that the interim manager followed clear and robust disciplinary procedures where poor practice was identified. It was addressed through staff supervision and performance management, supporting staff through extra training and setting targets to improve performance. This meant that people who used the service could feel confident that the provider had systems to improve poor practice.

Requires improvement

Is the service effective?

Our findings

People we spoke with gave us mixed views about their experience of the service. One visitor said, "My [person using the service] two appointments with dentist have been missed and I was not informed that their appointment date letter had come, I would have made alternate arrangements." Another visitor told us "My mother's bath is not clean. Her laundry has gone missing and once it was shrunk and the night carers are very abrupt." However another person told us, "The care is outstanding."

We looked at how they managed people's weights and saw that where they fluctuated care plans indicated that a food and fluid chart had been implemented. We did find that in one instance there was no plan in place and were advised that they no longer required one. We saw that the person had been referred to the GP and other relevant healthcare professionals regarding their weight loss. We saw they had been recommended thickened fluids in April 2015. It was recorded that the person refused to accept thickened fluids. This was not referred back to the relevant healthcare professional until June 2015. This was brought to the manager's attention who said they would ensure the records were correct and a further referral would be made regarding the person's ability to manage fluids. We observed the person to be drinking without problem.

In discussion with a visiting healthcare professional they told us they visited the service regularly and could see that improvements were being made by the new manager. They said that referrals were made to them in a timely manner and staff followed any guidance that was given.

We also read in a person's care plan several references to them displaying aggressive or sexualised behaviour. There was no one place where staff could read what this behaviour was, what triggered it or what action they should take to reduce the risk.

We noted a person was at risk of developing pressure ulcers. We saw that pressure cushions were in place and a pressure mattress. However two mattresses we looked at were set incorrectly. This meant that the mattresses would be ineffective and the person could continue to be at risk of developing pressure ulcers. There was no advice to staff in care plans about what the correct settings for mattresses and when they had a duty to report to district nurses. We brought this to the manager's attention who made arrangements for the district nurse to change the settings. The manager told us that the provider was introducing new care plans and this should address the short comings we found. Following the inspection the manager sent us an action plan detailing how they were progressing with moving care plans to the new paperwork.

Care staff in the Lodge told us they had training around awareness of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who lack mental capacity to make decisions and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. A care told us "We have had Pearl training." Pearl is a training course that has been developed by the provider to help care staff understand the needs of people who use care services particularly where they have dementia.

Plans we looked at did identify whether a person had capacity and where a person was assessed as not, there were plans in place to support them. However we found that capacity assessments and best interest's decisions were not carried out consistently. For example in relation to people who needed bed rails. Information was not clear who had made the decision and if the person had capacity why they were not consulted in that decision. We found that bed rails assessments and consent forms were not always in place. We also found some general information with regards to people's capacity. For example one care plan stated 'Informal diagnosis of vascular dementia. Unable to make any complex decision. These will be made by family and health professionals.' We brought this to the interim manager's attention who told us they would revisit all care plans to ensure that capacity assessments followed current guidelines.

We also saw that in the notes of three people's care plans references were made to them using reclining chairs. This meant the person would be unable to get up without a member of staff supporting them to lower the chair. However there was no acknowledgement that this may be restrictive and so should be referred for a Deprivation of Liberty Safeguarding assessment. The interim manager informed us following the inspection that this had been reviewed and appropriate action taken.

People who used the service told us they felt supported by care staff who appeared trained. One person said, "The

Requires improvement

Is the service effective?

staff are very nice". A visiting relative told us, "I have been regularly visiting since May and most of the relatives who visit have said they are quite happy about the care here for the dementia residents." Another visitor told us, "I looked at eight homes before deciding on this one. I never dreamt that [person using the service] would have the care they have had."

We looked at care staff training records. These showed that the provider had a range of training that included safeguarding and moving and handling training. Care staff were then supported to attend training that would develop their skills and abilities further. We looked at supervision records and these showed that training needs were addressed and care staff were offered training opportunities. We saw that the interim manager was investigating the possibility that ancillary staff such as the cook and the cleaner being supported to undertake their level 2 NVQ training in their relevant areas. (National Vocational Qualifications (NVQs) are work based awards in England, Wales and Northern Ireland that are achieved through assessment and training.) Staff said they do have eLearning, but it would be nice to have in house training too. A care staff said "I would like some training on diabetes." Another staff member said "I'm just finishing my NVQ level 3."

The unit manager for the Lodge told us, "We have an induction booklet and a two day induction which includes shadowing another staff. They do moving and handling and have eLearning in the first six weeks." The interim manager confirmed the induction arrangements for new care staff adding that the length of time a person shadowed depended on if they had previous experience and how confident they felt to care for someone.

People told us they received sufficient to eat and drink and that the menu provided choices. A relative said "The food is really good, they offer homemade cake. If someone needs a pureed meal it's presented nicely. Care staff help feed my [person using the service] they take their time it's done really well."

We observed lunchtime at The Lodge which was calm and not rushed and popular music was playing. There was plenty of space and tables were laid with tablecloths, mats and cutlery. The food smelt good and was well presented. It was served by staff from the hatch, already plated and with gravy. This meant there was no opportunity for people to help themselves. We did see the cook ask people what they would like for lunch that day at 11.15.am. There was a choice of Cornish pasties. The cook told us they were homemade. We also saw that photographs of the food were available to assist people in making their choice. Staff told us, "Everyone's put on weight, but we can do weekly weights, we monitor and refer to the GP. We use full fat milk."

During the meal a person became distressed and reassurance was given and this calmed the situation. Where people needed full assistance with their food this was done sensitively by staff and communication was good. People were not rushed. Where other people needed intermittent support or prompting, this was given. Dinner was served on blue plastic lipped plates and two people had adapted drinking vessels. We saw care staff use cushions to support one person in their wheelchair to help them to sit up straighter. This meant people received their meal in a pleasant environment and were supported in a way that promoted their dignity.

Requires improvement

Is the service caring?

Our findings

We received mixed comments for people and relatives who used the service. A relative told us, "[Person who used the service] incontinence pad is kept on for no reason, they are never offered drinks to avoid dehydration." Another relative told us, "My [person who used the service] is a tea drinker; staff would not make them one even though we asked and said to wait for the trolley round." However another relative said, "Can't fault the carers in this place. I visit at different times, but not the night times." They added, "[Person who used the service] hair is done, their clothes are tidy only once were they wearing wrong clothes."

We found a difference in the way people were supported by care staff in each unit. We saw that people were not always treated with kindness in the House whereas in the Lodge care staff were patient and compassionate with people who used the service. For example a person who lived at the Lodge became distressed so a member of staff offered comfort by sitting and talking with them and helped them become less distressed. In the House we noted there were long periods where the lounge area was left unattended or staff came into the lounge to carry out a task such as assisting someone to transfer from their wheelchair to a chair. We saw people sitting with their clothes rumpled so legs or stomach areas were exposed. We also saw a person with a catheter bag exposed beneath their trousers. At no time did staff offer to rearrange people's clothes. This did not support people's dignity.

We witnessed a negative interaction between two members of the kitchen staff in the Lodge. This was done in front of people who used the service and could have distressed people who used the service. On the second day of our inspection we noted a member of the kitchen staff giving out tea during the morning tea round in the House. This was done without any interaction with people who used the service. They were not given a choice of drink. When they were given a biscuit no choice was given and they were not provided with a plate. One person said they did not want a biscuit. It was taken back and put back with the other biscuits. Again there was no conversation from the kitchen assistant. This was brought to the manager's attention who confirmed following the inspection that this matter had been dealt with.

Throughout the two days we were present we noted that people in the Lodge were routinely offered cold drinks but in the House jugs of juice were available but there were no glasses for people to use neither did we see staff offer to provide people with a drink. We brought this to the manager's attention. We were told following the inspection that more beakers had been bought to ensure people had access to them so they could have drinks when they wanted.

A relative who spoke with us told us they had come in that day to meet with the manager to discuss their [person who used the service] care plan. They told us, "I feel involved in developing my [person who used the service] care plan." The manager told us they were going through everyone's care plans to ensure they were relevant and introduce the provider's new paperwork. Visitors also told us they were made to feel welcome by staff and were able to visit whenever they wanted. One person told us, "We can visit whenever we want including meal times." We saw a visitor was welcomed by name and offered a drink. They were brought the drink as was their relative.

'We asked care staff how they supported people when they were at the end of their lives. We were told, "When someone dies we ring the manager and the relatives. It depends whether the death is expected or not. We might call the police and GP. We might ring the undertakers or the family might want to do it." We looked at people's care plans to see what information there was to ensure people had their wishes met for their end of life care. We also saw that the manager was in the process of updating plans in this area.

Requires improvement

Is the service responsive?

Our findings

The interim manager had made attempts to make care plans more person centred by including basic information about the person in the front of the care plan. This information included such things as what time they liked to get up and go to bed. Following the incident where we had to intervene on a person's behalf we looked at this person's care plan. The personal information said they liked to be got up at 7am. However the person was still in bed at 9.15am.

The care plans we looked at were not always easy to understand or work out what a person's care needs were. Crucial information about a person's changing needs often could only be found by reading through several entries in the evaluation logs.

We found some information in care plans was not personalised and in some instances was confusing. For example, there were confusing records about the use of heal protectors. One entry said they had been discontinued, another said they should still be used. They were in use on the day. We brought this to the manager's attention who told us they would arrange for it to be made clear what should happen.

On another occasion we noticed a person was slumped to their left in their chair and appeared uncomfortable. Staff did not attend to this person until we prompted them. Following this the paramedics were called as the person appeared unwell.

Again we noticed the difference in how staff responded in the two units. In the Lodge staff appeared far more alert to people's needs and were able to assist and respond to people promptly whereas in the House staff appeared unaware of people's needs. A member of staff in the Lodge told us they had attended some in-house training developed by the provider to enable staff to understand the needs of people who use care services. They said, "I have been on Pearl training, challenging behaviour and understand the vulnerability of the service user." Following the inspection visit the manager sent us an action plan that identified further training for staff in the House including attending Pearl training. The manager told us that Pearl training is used to help staff develop a better understanding of what it is like to be a person in a care home and totally reliant on staff for their daily care needs to be met.

The interim manager told us they had introduced a service user representative. Following a discussion with interested people a person had been nominated to take on this role. We spoke with the person who told us they were unsure what the role would entail but were sure they would learn.

The inconsistency between the two units was also apparent when it came to activities. The activities organiser was away during our inspection. In the Lodge staff were able to engage in meaningful activities with people. For example we saw staff reading with people and talking with them. However we saw no such engagement in the House. People who used the service told us, "There is not much activity apart from draughts, read the newspaper, knitting and bingo since I came in March". We spoke with another person who said, "I would like to go back to my village, which is very near here. No one would do it." They added, "I shall tell the manager." A visitor told us, "There are some activities that I see happening, though my [person who used the service] is not an activity person." Staff told us, "When the activities coordinator is here we are happy with the activities. We don't really take people out, that's mainly the families."

Staff told us there was no one with particular spiritual or religious needs. We were told that "One lady has communion on a Sunday." We saw that care plans did identify where people had specific cultural or religious needs and how these would be met. Staff were also able to give us information about people's cultural backgrounds and how these were supported. A member of staff said, "Everybody's different. Some people have different routines every day. Even where people don't have capacity, we still give them choices every day."

Staff knew how to respond to a complaint and said the only issue previously was staffing and that was getting better.

Some visitors were aware there were relative's meetings. One visitor told us, "There is a meeting due soon, they are usually held quite regularly." Another visitor told us, "The last meeting was in May, since then nothing is happening here if we have any views or issues."

People told us they were able to go to bed when they wanted to, however they did find that sometimes getting

Requires improvement

Is the service responsive?

up was a problem as staff were not always available when they wanted to get up. A person told us, "I am my own self and have my choice of going to bed, but in the morning they come when they can give me a wash as wheelchair is to be used." One visitor said, "My [person who used the service] does not get their preferred breakfast and their choice is not managed. Their choice of breakfast is very European and not a British breakfast including salads and cereals." They added, "I like activities like gardening, visiting bird sanctuaries and it seems nothing is offered here."

Requires improvement

Is the service well-led?

Our findings

There is currently no registered manager for this service however the interim manager told us that they have started the application process to become registered.

The two units were not managed in a consistent way. The Lodge had a unit manager who gave a clear guidance as to the standard of care that should be given and staff knew and understood their roles as a result. A member of the staff working in the Lodge told us, "We work really well together as a team up here." Another staff member said, "We aim to provide good care, it's their home, it's how I would want my mother treated."

In the House a deputy manager was in charge. There were issues around some staff not wanting to work flexibly and provide cover at the Lodge. This meant that when the interim manager was not on duty there was no management cover over both parts of the service. Following our inspection the interim manager told us that this issue had been dealt with and improvements in staffing flexibility had been made in ensuring that staff would work in both units.

The interim manager told us that they had introduced new ways of improving communication throughout the service. These were used across all the provider's services and included daily meetings with staff representatives across the service including housekeeping and the kitchen. These meetings were intended to ensure the manager was kept up to date with anything that may impact on the running of the service.

Staff we spoke with knew about the whistleblowing procedure. They felt comfortable to report internally and externally and confident if they reported things to senior managers it would be dealt with. One staff member told us "I feel well supported at my level." However another one said, "I don't really feel well supported because we have another new manager and they all want different things and different changes. I do now feel listened to, if I raise something, it's addressed."

Staff told us that they have regular team meetings. "We have communication all the time, staff meetings are about 3 monthly." Another member of staff said, "We don't have management meetings, but we have started having the ten minute meetings for unit heads."

The provider had recently introduced a new quality assurance system that relied on people who use the service, visitors and staff completing a questionnaire via an electronic tablet that was kept in the entrance hall of the service. This could be regularly reviewed by the manager and they intended to respond promptly when suggestions were made. As this was relatively new the manager was unable to show us any actions they had taken as a result of this system.

The provider had a quality monitoring system that was used throughout all their services. The manager must complete the system and show what action had been taken where any shortfalls were identified. We were shown how incidents were investigated and what learning took place as a result. For example, where a person had fallen it showed when and where this occurred and looked at what needed to happen to minimise any future risk.

Prior to our inspection we spoke with the local authority contracts office who told us that the manager and provider had been working closely with them to improve the care provided by the service.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

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