Heartwell Care Ltd

# Heartwell House Residential 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? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

## Overall summary

This inspection took place on 7 January 2015 and was unannounced.

We previously carried out two unannounced inspection of this service. These took place on 21 May/11 June 2015 and on 21 September 2015. Over the course of these inspections six breaches of legal requirements were found and, following each inspection, the service was judged to be 'Inadequate' overall.

After these inspections the provider sent us an action plan stating what they would do to meet legal requirements in relation to the breaches.

Heartwell House Residential Care Home provides care and support for up to 13 people with learning disabilities or mental health conditions. It is situated in a detached

# Summary of findings

house in Leicester City. The home has two lounges and a dining room. There are 11 single bedrooms and one double bedroom situated on the first and second floors with stairs for access.

Heartwell House is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. At the time of our inspection a registered manager was employed at the service.

We found the atmosphere in the home had improved and the people using the service were more involved in how it was run. Staff were caring and friendly towards the people using the service. We observed some good interactions when a staff member encouraged people to join in activities and conversations. Staff also consulted with people before they supported them and enabled them to make choices about their daily routines.

We acknowledged that staff had worked hard to improve this service, although some further improvements are needed.

Although most people we spoke with said they felt safe at Heartwell House one person's risk assessments were in need of improvement to address a safety issue in the home.

Staff understood safeguarding (protecting people who use care services from abuse) and knew what to do if they were concerned about the well-being of any of the people who used the service. Some improvements were also needed to the way medicines were stored and administered.

There were enough staff on duty to meet people's needs and do activities with them. Staff supported people effectively and were trained to meet most of their needs. We observed that staff were skilled in providing reassurance and support to people if they became distressed.

Staff had a better understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However some improvements were needed to mental capacity assessments so they took into account people's fluctuating capacity due to their mental health needs.

People told us they liked the food served at the home and they could have a drink and a snack when they wanted. A staff member told us she cooked spicy and non-spicy versions of the meals to suit people's different tastes. Some improvements were needed to one person's nutritional care plans.

People told us they took part in activities including minibus trips, walks, playing snooker in the pub, and going to the park or the library. Records showed people were involved in choosing activities at residents' meetings and the activities they requested were provided.

People using the service knew what to do if they had any concerns or complaints about the service. Records showed the home's complaints procedure had been explained to them so they knew who to go to if a problem arose.

Improvements had been made to how the home was run. Policies and procedures had been reviewed and improved and new ways of working and records keeping introduced. People using the service and staff had been involved in discussions about the changes and improvements that were being made.

You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not consistently safe.

Improvements were needed to how the risk of falls was managed.

Staff were trained in safeguarding and knew what to do if they were concerned about people's welfare.

There were enough staff on duty to keep people safe and meet their needs.

Staff were safety recruited to help ensure they were appropriate to work with the people who used the service.

Improvements were needed to the way medicines were managed.

**Requires improvement**

**Is the service effective?**
The service was not consistently effective.

Staff mostly had the training they needed to provide effective care and support.

Consent to care and treatment was sought in line with legislation and guidance.

People had a choice at mealtimes and were supported to eat healthily.

Improvements were needed to way people's health care needs were monitored.

**Requires improvement**

**Is the service caring?**
The service was caring.

The staff were caring and kind and got on well with the people using the service.

People were actively involved in making decisions about their care, treatment and support.

Staff treated people with dignity and respect and protected their privacy.

**Good**

**Is the service responsive?**
The service was responsive.

People received personalised care that met their needs.

People has access to a range of group and one to one activities.

People knew what to do if they had any concerns about the home.

**Good**

**Is the service well-led?**
The service was well led.

**Good**

# Summary of findings

People using the service were involved in how the home was run.

Improvements had been made to policies, procedures and working practices in the home so as to promote a more personalised and empowering culture.

Audits were carried out to check on the quality of the service.

# Heartwell House Residential 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.

This inspection took place on 7 January 2016 and was unannounced.

The inspection was carried out by an inspection manager, two inspectors, a pharmacy inspector, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert for this inspection had experience of the care of people with learning disabilities.

We used a variety of methods to inspect the service. We spoke with five people using the service, the provider (who is also the registered manager for the home), the deputy manager, the home's consultant (a person who provides expert advice professionally), and three care workers.

Due to communication difficulties not all the people using the service were able to share their views with us so we spent time with them and observed them being supported in the lounge and dining area.

We looked at records relating to the safety of the people using the service, staff recruitment, and the management of the service. We also looked in detail at four people's care records. Prior to the inspection we spoke with staff from the local authority and the fire service.

Requires improvement

# Is the service safe?

## Our findings

We looked at how risk was managed in the home. Records showed that risk assessments were completed and measures to manage risks were mostly detailed in people's care plans. People's care plans promoted positive risk-taking. For example, one person using the service told us that it was important to them that they are able to go out independently into the local community two or three times per day.

During our inspection we observed staff support the person to do this by checking they were wearing appropriate clothing for the weather and that they had sufficient money. Staff also asked the person about the route they would be taking and when they expected to return to the service. This was consistent with the measures recorded in the person's care plan to keep the person safe.

However another person's risk assessments lacked detail. They showed that the person was at risk of falls. Their falls risk assessment was last reviewed on 8 September 2015 and stated that the person needed to be reminded not to get up too quickly in case they fell, but there was little other information.

Records showed that since the review the person had fallen while out in the community and in also their room, but the risk assessment had not been updated as a result. We talked to the person in question about their risk of falling. They told us, "I'm worried about falling on the stairs. I want to stay in this room [on the second floor] and I want staff to go with me on the stairs."

However there was no mention in the risk assessment of the safety or otherwise of the stairs, or any safety measures in place to reduce the risk of the person falling in their room or in the community. Nor were there any instructions to staff on how to assist this person with their mobility if this was needed.

We asked staff how they helped to keep this person safe. They told us that where possible they accompanied the person up and down the stairs to reduce the risk of them falling again. However this was not in the person's records and there appeared to be some confusion amongst staff about whether this person should ever go up and down the stairs unsupported. There was also confusion about what a staff member could realistically do if the person fell while they were being accompanied.

The person's room was on the second floor up two flights of steep, narrow stairs. There were no handrails on sections of the stairs and it appeared that nothing had been done to make the stairs safer for people using the service.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment.

These concerns were discussed with the provider who agreed to address them.

Some people told us they felt safe living in the home. One person said, "I am safe here. I have no worries about my safety." We observed that people appeared to be relaxed and at ease with the staff who were on duty that day.

At our September 2015 inspection we found that the provider did not have effective systems and processes in place to ensure people using the service were protected from abuse. Following this inspection the provider sent us an action plan stating that staff would be re-trained in safeguarding and checks made to ensure they understood their safeguarding responsibilities.

At this inspection records showed that staff had attended safeguarding training and this was followed up at a staff meeting where safeguarding was discussed. The meeting minutes stated 'all staff have a better understanding of how the investigation takes place and who is involved'. During the meeting staff were asked to demonstrate their understanding of safeguarding which they did to the satisfaction of the provider.

The staff we spoke with knew what to do if they were concerned about the well-being of any of the people who used the service. They were familiar with the provider's safeguarding and whistleblowing polices. They said they would report any concerns to the provider or the deputy manager who would then tell social services. This meant staff understood how to protect people who use care services from abuse.

One person using the service told us, "There's always staff here if you need them." The home was well-staffed during our inspection and staff had the time they needed to meet people's care needs and do activities with them. The staff

Requires improvement

# Is the service safe?

rota showed that the staffing levels we observed were consistent with the usual staffing levels. Throughout our inspection staff were visible and went about their duties calmly.

Since we last inspected several new staff had been employed at the home. Records showed they had been safely recruited with appropriate checks being carried out to help ensure they were suitable to work with people who use care services. One person told us, "The new staff are fine but don't know me well yet. They look after me well though."

We checked records to see if staff had been safely recruited. Staff files showed that the provider's recruitment process had been followed. The necessary documentation was in place to demonstrate staff were fit to work in the home. This included evidence of checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and ensure that staff employed are of good character.

We looked at how people's medicines were managed so they received them safely. One person told us, "I get my medicines on time." Another person had had their medicines reviewed and changed since we last inspected and it appeared that their well-being had improved as a result.

We looked at how medicines were stored. We saw the fridge in the kitchen had a separate container clearly labelled and allocated for medicines. The fridge was maintained and recorded at an appropriate temperature to ensure medicines remained effective.

Medicines in containers were clearly labelled with a name and a photograph for each person living in the home to ensure safe administration of medicines to the right person. We looked in detail at the medicine administration records (MAR) and their care plans for three people using the service. This showed that people were getting their medicines as prescribed. We were informed that there had been no medicines related safeguarding incidents and so there was no information available of any investigation or reporting.

However we noted that some improvements were needed to the way medicines were managed. We also saw the medicine cupboards key was included with the rest of the keys used in the home. This meant there was potential for unauthorised access to the medicine cupboards by any member of staff.

We found medicines were kept securely in locked cupboards. However one of the medicine cupboards was also used for the storage of cigarettes belonging to people using the service. This was inappropriate and meant staff frequently opened the cupboard to gain access to people's cigarettes which made the medicines less secure.

We found the staff administering medicines did not always follow the provider's medicines procedures. The provider had clearly highlighted in this that staff must sign the MAR (medicines administration record) after the medicines had been administered. But when we observed a medicines round we saw the staff member carrying this out did not always wait for the person using the service to take their medicines before they signed the MAR. This meant there was a risk of staff not being aware if people did not take their medicines.

There were no individual protocols for 'when required' medicines were to be given. The provider's medicines policy lacked detail on this so staff were not fully aware of their responsibilities with regard to this type of medicines. We also saw handwritten MARs which had not been checked for accuracy or signed by a second trained member of staff before it was first used. We were informed that there was no covert administration. However, if the need arises, there was no clear procedure for giving medicines in accordance with the Mental Capacity Act 2005.

We found only trained senior care staff administered medicines. Current training was overdue, although staff competency assessments had taken place. However no regular or random medication audits had been carried out to ensure staff administering medicines remained competent. We also advised the provider to ensure medicines for people regularly 'on leave' from the home were dispensed by the supplying pharmacy in advance to help ensure these were administered safely.

We discussed these issues with the provider who agreed to take prompt action to address them. The provider also told

Requires improvement

# Is the service safe?

us that the home's new consultant was a qualified nurse who would be carrying out a full audit of the home's medicines policies and procedures to help ensure they were safe.

Requires improvement

# Is the service effective?

## Our findings

We looked at how effective staff were in supporting the people using the service. One person told us, "The staff seem fine and they look after people well. If anyone is ill the staff deal with it." We talked with staff about their roles in the home. One staff member said, "My responsibilities include playing games with the residents, involving them in games or conversations, making meals for them, supporting them and writing reports." Another staff member said, "We are here for the residents."

Staff were trained to meet most of the needs of the people using the service. The provider's training matrix showed staff had completed a range of courses in general care and health and safety. However staff had not had training to enable them to support people who had specific individual needs, for example people with diabetes and those at risk of malnutrition. We discussed this with the deputy manager who was responsible for staff training in the home. She told us she was in the process of identifying training needs for the next 12 months and planned to include courses on diabetes and nutrition in the forthcoming programme.

Since we last inspected some new staff had been employed and we looked at how they were supported to begin work in the home. Records showed they completed an induction including introductory courses in care, reading policies and procedures, one-to-one tuition with the deputy manager, and shadowing experienced staff as they worked. Competency checks were carried out throughout the process to help ensure new staff understood what was expected of them.

The home's consultant told us that plans for a more comprehensive induction were in place and showed us the documentation for this. The consultant said the new induction would put more emphasis on the needs of people with mental health issues and learning disabilities so that staff could gain expertise in these areas.

Records showed that staff were supported through regular staff meetings and supervisions. Minutes of staff meetings indicated that the provider encouraged staff to understand and contribute to discussions about the home. For example, planned improvements to the service were discussed in a recent meeting. Records also showed individual staff member's development needs were discussed with them on a one to one basis and they were encouraged to improve their skills and knowledge.

During our inspection we saw staff supporting people effectively. For example, one staff member provided reassurance to a person who was becoming agitated. We saw that the staff member followed intervention techniques as recorded within the person's care records. The person responded positively to this appearing calmer and more settled after the staff member had intervened.

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 Acct 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 there is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our May/June 2015 inspection we found that the provider had not acted in accordance with the MCA and people's human rights may have been compromised as a result. Following this inspection the provider sent us an action plan stating this had been addressed. They told us a DoLS application had been made to the relevant department for one person who might be in need of this.

At this inspection we checked whether staff at the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the care records for one person who had a DoLS authorisation in place due to the levels of supervision they needed. We found the provider had ensured that all staff were aware of the DoLS authorisation and had actioned any recommendations or requirements identified as part of the person's best interest assessment. This meant the provider was meeting their responsibilities with regards to this DoLS authorisation.

Requires improvement

# Is the service effective?

However some mental capacity assessments were in need of improvement. This was because they did not always acknowledge the effect of fluctuating capacity on people's ability to consent to care and treatment. For example, care plans showed that some people experienced episodes of mental distress which may impact on their ability to keep themselves safe or make decisions in their best interests. However, this was not always addressed in their care plans. We discussed this with the provider who agreed to update care plans as necessary.

People told us they liked the food served at the home and they could have a drink and a snack when they wanted. One person said, "The food is all right here. I can get snacks between meals if I want to." Another person commented, "I like the food and we get tea whenever we want." And a third person told us, "I can get a sandwich after dinner if I am hungry."

Lunch was served during our inspection and consisted of aubergine and peas curry, lamb curry, rice, salad and chapattis. People went into the kitchen and asked for the items they wanted and this was served to them in the dining room. A staff member told us she cooked spicy and non-spicy versions of the meal to suit people's different tastes.

Records showed people's nutritional needs were assessed and care plans completed but those we saw did not always reflect people's current dietary needs. For example, we spoke with one staff member who told us that they provided one to one support for one person, sitting with them as they ate their meals to provide encouragement. However this arrangement was not in the person's care plan. This meant that staff might not always have the information they needed to provide effective care for this person with regard to their nutritional needs. We discussed this with the provider who agreed to review and update the care plan in question and others if appropriate.

Care records also showed that people's weights were measured and recorded monthly. Where people were felt to be at risk of poor nutrition, they were referred to their GP and daily fluid and food intake charts were completed.

At our May/June 2015 inspection we found that the provider had not ensured people's health care needs were appropriately met. Following this inspection the provider sent us an action plan stating that care plans and risk assessments would be updated to ensure people's health care needs were appropriately met.

At this inspection we looked again at how people were supported to maintain good health, accessed healthcare services, and received ongoing healthcare support. We found that care plans and risk assessments for people's health care needs had been improved and updated. Where people using the service had declined support from staff to manage their health needs, such as diabetes, care plans included a health risk assessment for staff to respond to any adverse signs and symptoms associated with the person's health needs. This meant staff would know when to alert medical professionals if a person's health deteriorated.

Records showed that people were seen routinely and when required by a range of health and social care professionals including GPs, community psychiatric nurses, opticians, and chiropodists. Although a brief statement on the outcome of appointments was recorded in the person's care plan, there was no evidence that the views of health professionals were reflected in people's care reviews. This meant there was a risk that changes to their healthcare needs could be overlooked.

We discussed this with the home's consultant and the provider. The consultant showed us a new set of assessment and care planning tools that were in the process of being introduced at the home. The consultant said these allowed for more detailed monitoring of people's physical and mental health care needs and would ensure that when people's care reviews were held the views of health professionals would be included.

Good

# Is the service caring?

## Our findings

We asked people what it was like to live at Heartwell House. One person said, "I like it here. You get to do what you want to do." Another person told us, "It's OK. The staff are alright. They are good to me."

We saw that staff were caring and friendly when they spoke with the people using the service. Some staff were particularly good at interacting with the people who used the service. For example in the afternoon five people using the service were watching a quiz on television. The staff member present encouraged people to answer the questions and congratulated them when they got them right. This had a positive effect on people who became more interested in the activity as a result.

We also saw the same staff member asking people whether they'd enjoyed a recent party in the home and talking with them about the food they'd had. Again people responded positively to this approach and joined in the conversation. Other staff, although kind, had minimal interaction with the people they supported. We discussed this with the provider and suggested that staff who were less confident in interacting with people might benefit from further support and training in how to do this. The provider said he would address this.

We observed that if a person became agitated staff responded appropriately. For example, while in one of the lounges we saw one person became distressed and then began to distress the person sitting next to them. A staff member immediately went to them. They calmly talked with them and reminded them of how to behave appropriately to others. The person became settled and was reassured by the staff member's actions. They then apologised to the person sitting next to them. This was a positive outcome and the staff member then engaged all the people present in a group discussion which they appeared to enjoy contributing to. This resulted in a good atmosphere in the lounge.

One person told us told us they were involved in making decisions about their care, treatment and support. They said, "I am involved in the annual review where my care is discussed." During the inspection we observed that staff always consulted with people before they supported them and encouraged them to make choices about their daily routines.

However some people using the service have signed consent forms on their care records that were broad statements of consent or agreement to adhere to the service safety procedures rather than decision-specific. This meant that people had not had the opportunity to consent to various aspects of their care. Records also showed that people's care plans were reviewed monthly. However there was no evidence of people being involved in these reviews. We discussed this with the provider who said he would address this.

Throughout our inspection we observed staff treating people with respect and dignity. For example they knocked on people's bedroom doors and waited to be asked prior to going into their rooms. They also made sure doors were closed when attending to people's personal care needs. If people needed assistance in communal areas staff provided it discreetly to ensure people retained their dignity.

Records showed that people's privacy was taken into account when their care was planned for. For example, one person's records reminded staff, 'I don't like it when someone else enters my private space without my consent.' One staff member told us, "Some people don't mind us going into their rooms to clean them but others do and we have to discuss it with them first. It's in the records" This showed that staff were aware of people's different requirements with regard to their privacy and respected these.

Good

# Is the service responsive?

## Our findings

We looked at how people using the service received personalised care that was responsive to their needs. Since our last inspection the provider has continued to improve and update care plans. The provider told us some of this had been done in conjunction with the local authority whose staff have given him advice and assistance.

During our inspection we saw many examples of staff responding to people's needs promptly and efficiently. If people needed food, drink, personal support, or company staff provided this. We talked with staff about how they responded to people's needs, in particular those who had limited verbal communication skills. Staff told us that people's care files provided a good introduction to people's needs and getting to know the people they supported helped to give them a better understanding of their needs.

The care plans we sampled were personalised and including instructions for staff on how to provide responsive care. They identified people's individual needs and set out how they were to be met. For example, one person's care plan stated they had communication needs and told staff to use simple statements, key words, body language and pictures to interact with them. We observed staff following this care plan during our inspection with positive results.

Records showed that people using the service had signed to say they agreed with their care plans. For example, one person had signed to confirm they wanted to lock their bedroom door at night. Records showed they understood this prevented staff from doing a regular check on them and acknowledged that staff did had a spare key they could use in emergencies. This showed that the person had been involved in their care plan and their wishes respected.

People's care records included personal profiles to help staff get to know them. These type of profiles usually includes information about a person's history, friends and family, like and dislikes, and achievements. This enables staff to see the individual person at the centre of the support process, and give them ideas for topics of conversation when supporting the person. However not all personal profiles contained this type of information. For example, one person's profile contained only limited information about them and this was mainly negative. But when we met this person we found they had so far led an interesting life with some significant achievements. We discussed this with the provider who agreed to review personal profiles to ensure they were more personalised and reflective of the lives of the people they referred to.

We asked people about the activities they took part in at the home. One person said, "I spend my time watching TV and listening to the radio." Another person told us, "Others sometimes play games but I don't take part as I don't like to concentrate." Some people said they went out in the home's minibus and for walks or to the local shops with staff or on their own.

We also talked with staff about activities. Staff told us that indoor activities included board games and cookery. Outdoor activities included driving into town, walking, playing snooker in the pub, and going to the park or the library. Staff said people usually went out in the minibus in the mornings and evenings, and in the afternoon people preferred to relax in the home in their own rooms or in communal areas.

Staff recorded activities in a daily log and on each person's individual 'daily monitoring sheet'. This meant it was possible to get an overview of the activities provided at the home.

People using the service had been involved in the choice of activities. For example, minutes of a recent residents meeting showed that everyone present was asked what activities they would like to do. People asked for minibus trips, board games, walks, and cookery. Records showed that since then all the requested activities had been provided.

People using the service told us that if they had any complaints they would tell the staff. Staff said they would report any complaints to the provider.

This was in keeping with the provider's complaints procedure which was in the statement of purpose and displayed on a noticeboard in the home. It contained up-to-date information about who people could complain to if they were dissatisfied with any aspect of the service. It included contact details for the local authority should people using the service or others want to take a complain to an external person.

Records showed complaints had been discussed in detail with the people using the service at a residents meeting, and on a one-to-one basis with people who were not at this

Good

# Is the service responsive?

meeting. People were asked if they had any complaints and whether they knew who to contact if they wanted to make a complaint. It was also made clear to people that if the person they reported a complaint to didn't do anything they could take the complaint to the local authority or their community psychiatric nurse.

Records showed that since we last inspected one concern had been raised with the provider. This had been addressed and the person who raised the concern given a full explanation and outcome. This was positive as it showed the provider listened to people who raised concerns and took their concerns seriously.

Good

# Is the service well-led?

## Our findings

At our September 2015 inspection the provider did not have an established system or process in place to enable him to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity.

Following this inspection the provider sent us an action plan stating that systems were now in place for regular monitoring and maintenance to improve the quality and safety of the service.

At this inspection we learnt that the provider had employed a consultant to assist the home's management to make improvements where necessary. We met with the consultant and provider and looked at some of the improvements that had been made since our last inspection. The consultant had introduced a series of audits which were in progress when we inspected.

Policies and procedures had been reviewed and improved and linked to the five fundamentals of care – safe, effective, caring, responsive and well-led. People using the service had been kept informed of policies directly relevant to them, for example those relating to safeguarding and complaints had been discussed with people individually and at residents' meetings.

New ways of working had been introduced, for example an initiative called 'service user of the day'. This involved each person using the service having a regular day when their care and other aspects of their life at the home were reviewed. The day included a meeting with the registered manager, a check to see if their room was in good order and that they were satisfied with it, liaison with their family, where appropriate, and a review of their care records. The person was also invited to choose their favourite meals and activities on that day. The consultant said 'service user of the day' would help to ensure that people were receiving an appropriate, personalised service they were satisfied with.

The consultant had also completed, in conjunction with staff, personal emergency evacuation plans (known as PEEPs) for all the people using the service. These were part of a home's fire safety measures and helped to ensure that staff are aware of anyone who might need assistance to leave the premises in an emergency. The consultant said completing the PEEPs had raised awareness amongst staff and people using the service about fire safety.

Other improvements included: the introduction of a daily handover record which gave staff a summary of events on previous shifts they needed to know about; new human resources and health and safety systems put in place; and the creation of a business plan for the home.

The provider and consultant also told us that the people using the service were becoming more involved in the running of the home. Plans were in place to involve them in choosing how the home was to be redecorated and in personalising their rooms. Minutes from a residents' and staff meeting showed that all the people who lived and worked in the home had been involved in discussions about the changes and improvement that were being made

At our May/June 2015 inspection we found that the provider had not notified us of significant events and incidents at the service including allegations of abuse and serious injuries to people using the service. Since then the provider has notified us where necessary of relevant incidents in the home. The will help to ensure that both the provider and CQC are aware of any events affecting the well-being of the people using 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.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**People were not protected from the risk of unsafe care or treatment.** |