Elmwood Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 25 January 2017 and was unannounced. Elmwood residential home is registered to provide accommodation with personal care for up to 38 people. The home is mainly for people over 65 years of age, who may have physical disabilities, long term medical conditions or memory loss. There were 36 people staying at the service on the day we visited.

This inspection was to follow up if the required improvements had been made following our last inspection 2 and 3 Aug 2016. At that visit, we rated the service as 'Requires improvement', as we found two breaches of regulations in relation to people's safe care and treatment and in good governance. We had previously visited the service 21 and 28 April 2016 and rated the service as 'Requires Improvement' because we identified breaches in both those regulations and in person centred care. Since the August 2016 inspection we received an action plan from the provider which outlined the improvements being made. The service has worked in partnership with the local authority quality assurance and improvement team to improve their systems and processes. They were using several new audit tools recommended by the local authority quality monitoring team.e met with two representatives of the provider on 9 January 2017 to discuss the improvements, which they said they had put in place.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

The service has 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 and associated Regulations about how the service is run. When we visited, the registered manager was on planned sick leave. Prior to their absence, they had notified the Care Quality Commission and the deputy manager was in charge of the day to day running of the home.

At this visit we found some improvements had been made in the quality monitoring systems at the home. However, these were still not fully effective, because breaches of regulation were also identified at this inspection. People's care records had improved. They were easier to navigate, information was accessible and older information had been removed and archived. People's records had more individualised details about each person, their likes and dislikes, and about their life before they came to live at the home. Care plans and risks assessments had been reviewed and updated and were more comprehensive.

However, two people with diabetes had no care plans to guide staff about how to meet their specific health needs. For another person totally dependent on staff for food and drink, poor record keeping of their nutrition and hydration records increased the risk those needs were not being met. We also found other gaps in people's daily records and in activity records which had not been successfully addressed through audits undertaken.

We identified concerns with regard to how complaints about individual staff performance were managed. Where repeated concerns about some staff had been raised, they had not been robustly dealt with and recurred. People remained at risk because the service's grievance and disciplinary policies about staff performance had not been followed and the audit of complaints should have picked up these issues and addressed them. We also found communication within the staff wasn't effective in maintaining and embedding the improvements.

Health and safety risks for people were reduced because improvements had been made to the safety of the environment. People were protected from scalds because thermostatic controlled valves were fitted in all areas to ensure hot water temperatures remained within the recommended range. Balcony rails had been repaired and repainted and new window restrictors were fitted in rooms which previously didn't have them, which reduced risks of people falling from the upper floors.

People were protected from potential abuse and avoidable harm. Staff had received safeguarding adults training and the provider had safeguarding and whistle blowing policies, so staff were clear how to report concerns.

People were supported by skilled staff that provided care at a time and pace convenient for each person. Improvements in medicines management had been made. The home was clean throughout, and odours were successfully managed. Monthly audits of cleanliness and infection control were carried out with actions taken in response to findings.

People and families said staff consulted and involved them in developing their care plan. People's care records included more person centred details about people's individual preferences about their life before they came to live at the home.

People enjoyed a range of individual and group activities. These included an exercise class, knit and natter group, quizzes bingo and movie night. External entertainment such as musical entertainment was arranged as well as trips to local places of interest.

People said they were happy living at the home and with the quality of care received. Residents meetings were held where the views of people were sought about the food, activity programme and about whether people had any concerns or grumbles.

Although improvements had been made, two breaches of regulations were identified at this inspection. CQC have taken enforcement action in relation to one of those breaches by serving a warning notice. We will carry out a further inspection within the next six months to check this has been met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safer because improvements to the environment had been made.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

People were supported by enough staff so they could receive safe care at a time and pace convenient for them.

Accidents and incidents were reported and monitored. People's individual risks were assessed and actions taken to reduce them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Improvements in care records had been made, and they were more personalised. However there were some gaps in records.

People were at increased risk because of a lack of care plans for people with diabetes, gaps in daily records, activity records and in a person's food and fluid records.

People and their relatives felt confident to raise concerns with staff. There was a complaints process, and complaints were investigated with actions taken to make improvements. However, repeated themes in complaints about some staff attitudes showed these issues were not being effectively addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People were not protected because the quality monitoring systems in place were not fully effective.

Although improvements had been made, further improvements were needed in record keeping and in how complaints about

staff attitudes were managed.

People, relatives and staff expressed confidence in the leadership at the home. However, we found some aspects of staff leadership were weak. We identified some problems with communication and limited opportunities to consult and involve the staff team.

People's views were sought and taken into account in how the service was run and examples suggested improvements were implemented.

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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 checked 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.

We undertook an unannounced focused inspection of Elmwood residential home on 25 January 2017. This inspection was done to check that improvements had been made. This was because when we previously inspected the service on 21 and 28 April 2016 and on 2 and 3 Aug 2016, we found the service was not meeting some legal requirements.

The inspection team comprised two adult social care inspectors. We inspected the service against three of the five questions we ask about services:Is the service safe, Is the service responsive? Is the service well led?

Prior to the inspection, we reviewed the information we held about the home. This included reviewing the previous inspection reports, notes of our meeting with the provider and their action plan, and from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met with 12 people using the service, and spoke with three visitors. We looked at six people's care records. We spoke with seven staff which included the deputy manager, three care staff, cook and kitchen assistant and housekeeping staff. We looked at quality monitoring systems such as audits of the environment, health and safety, care records and a provider visit report. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and at two staff files. We sought feedback from commissioners and from health and social care professionals who regularly visited the home and received a response from four of them.

Good

Is the service safe?

Our findings

People said they felt safe living at the home. People's comments included; "All very good and helpful;" "Safe, yes I think so;" and "Everyone is very helpful."

At the previous inspection in August 2016 we issued a requirement for a breach in regulations about people's safe care and treatment. This related to increased scald risks for people because of hot water temperatures in bedroom/bathroom areas exceeded the maximum of 44 degrees centigrade recommended by Health and Safety Executive for vulnerable people. Other health and safety risks found included a lack of legionella controls and absent/ faulty window restrictors and some balcony areas in a poor state of repair.

Since then, the provider sent us an action plan which showed thermostatic controlled valves were fitted in all areas people used. Water temperatures were checked regularly to ensure they remained within the recommended range and legionella checks were in place. Balcony rails had been repaired and repainted and new window restrictors were fitted in rooms which previously didn't have them, which reduced risks of people falling from the upper floor. A kitchen assistant said they were not happy the water in the kitchen was so cool. We asked the deputy manager why thermostatically controlled valves had been fitted in the kitchen. They explained this decision was taken because some people accessed the kitchen, when staff were not on duty, so could be at risk of scalding.

There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. This included plans to paint the exterior of the home in the Spring. Fire safety was well managed with regular checks of fire alarms, fire extinguishers and emergency lighting. Records of fire safety checks, fire training and fire drills were maintained. Each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of an emergency. Contingency plans were in place to support staff out of hours with any emergencies related to people's care or related to services at the home such as electricity, gas and water supplies.

Individual risk assessments were completed for people at risk of malnutrition, dehydration, of developing pressure ulcers and with choking/swallowing risks. Accidents and incident forms were completed, with evidence of further steps taken to further minimise risks. For example, where a person was identified at increased risk of falling, staff reviewed their footwear to make sure they fitted well, and added checks to make sure the person had their glasses and the call bell nearby. They also visited the person's room regularly to try and anticipate their needs and minimise the risk of further falls. However, one person told us about a fall they had a few days earlier where they suffered a grazed knee, which was not reported on an accident form, in accordance with the policy. The person confirmed staff had attended to them and the grazes were getting better. We made the deputy manager aware of this, so their records could be updated to reflect this.

People were protected from potential abuse and avoidable harm. Staff had received safeguarding adults training and the provider had safeguarding and whistle blowing policies, so staff were clear how to report concerns. All staff said they could report any concerns to the registered manager, deputy manager and were

confident they would be dealt with. No safeguarding concerns were identified since we last visited. There were secure arrangements in place to keep people's monies locked in a safe place, if they wished, to help protect them from financial abuse.

People were supported by skilled staff that provided care at a time and pace convenient for each person. People said call bells were responded to within a few minutes and regular audits of response times, showed a maximum time of nine minutes response time. On the day we visited there were seven care staff on duty, including the deputy manager. A dependency tool was used to check whether any changes in staffing levels were needed, as people's needs changed. Rotas showed recommended staffing levels were maintained, including with agency staff if needed. Care staff were supported by housekeeping, laundry, kitchen and maintenance staff. This meant people were able to get up and go to bed at a time convenient for them. Where people needed help they said they received this in a timely way.

No new care staff had been employed since we last visited but the service had appropriate recruitment systems in place. They interviewed staff, did checks of identity and qualifications, sought references and carried out police and disclosure and barring checks (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

A medicines management audit had been introduced and showed further improvements were made, such as reducing stock levels of medicines at the home.

The home was clean throughout, and any problem areas related to individual people's continence needs were being managed. Monthly audits of cleanliness and infection control were carried out in the kitchen and in all bedroom and communal areas with actions taken to address any concerns.

Requires Improvement

Is the service responsive?

Our findings

People reported they were happy living at the home. One said, "I'm very happy here" and another person said "Everyone is very nice to me." Staff knew people well, understood their needs and what they enjoyed doing. A relative who said the person chose to remain in their room, said staff popped in regularly to chat with them. Speaking about the deputy manager, several people appreciated they brought them an evening drink and had a chat.

At the August 2016 inspection, we found the standard of record keeping was variable. Some people's care records were more difficult to navigate because they contained a lot of duplicate documents and out of date information. Some risk assessments were not signed and dated, so it was unclear who wrote them or when they were written and some people's care plans were overdue for review.

At this visit we found some improvements in people's care records. However, we found inconsistencies in the level of detail and accuracy in some care records and gaps in record keeping.

For example, two people living with diabetes did not have any specific care plans that gave staff clear instructions about how to meet their health needs in relation to their diabetes. One person's nutrition, hydration and dietary requirements care plan did not record the person had diabetes, although the dietary assessment had identified this need. The person was at increased risk as they were feeling nauseous and hadn't much appetite and had lost three kilos in the past month. They had been seen by their GP and changes had been made to their medicines. Another person with diabetes didn't always make wise choices about their food. Their care record showed the deputy manager had discussions with their relative about their dietary preferences, although the person didn't necessarily agree with their relatives views. Despite these issues, they had no diabetes care plan to guide staff.

Two senior staff we spoke with knew which people had diabetes, and said kitchen staff knew which foods people with diabetes could safely have. However, a white board in the kitchen, about special diets and dietary preferences did not identify one of the people with diabetes. When we checked with kitchen staff about any dietary adjustments for people with diabetes, they said they did not have any specific foods for people with diabetes, such as reduced sugar jam. For example, when there was rice pudding for dessert, the chef said people with diabetes could have it as they didn't use a lot of sugar in cooking. Where there was Pavlova, they said fresh fruit was offered as an alternative, for people with diabetes, but they didn't make any alternative dessert for them. We followed these concerns up with the deputy manager who acknowledged that staff needed some training on caring for people with diabetes, and said they would arrange this. They said community nurses monitored people's blood sugars and advised them of any actions needed in response.

For a person who was wholly totally dependent on staff for food and drink, there were lots of gaps in their daily records of their food and drink. For example, the person was supposed to drink eight cups a day, about 1600 mls. On the 23 January 2017, their records showed they had two drinks, 300mls, and on 24 January 500 mls. On 22 January there was no record of whether the person had been given their evening meal or

whether they had been given their lunch the following day. There was no evidence that these gaps in records had been identified or steps taken to address them. Although the person looked well and hadn't lost weight,these poorly completed food/fluid records meant the person was at increased risk of dehydration and malnutrition because gaps in records meant we couldn't be assured about whether they were receiving all their meals/drinks. We had previously raised this issue previously at our inspection on 21 and 28 April 2016 and reported improvements on 2 and 3 Aug 2016. However, these findings showed the improvements have not been sustained over time. However, generally we observed people around the home were being given drinks regularly and those who needed were assisted to eat.

The service used pre populated daily checklists so staff could record each person's daily care. For example, details of each person's meals and drinks, personal care given, what they chose to wear, skins creams used and about their mood. There were numerous gaps in individual sheets, where no entries were made in many of the pre - populated sections such as in relation to meals, drinks, and mood. This meant they did not represent comprehensive records of the care and treatment provided. This checklist approach also made people's daily records seem task focused rather than person centred. Staff said if they had other relevant information, they would write this on the back of these daily notes.

An individual activity register was maintained, so staff could record what activities each person undertook. Also, there was nowhere for staff to record any detail about whether people enjoyed the activities. This meant the gaps identified through the audit had not been successfully addressed. At our previous inspection we highlighted lots of gaps in entries, which meant the activity book could not be relied on as an accurate record of each person's social activities. At this inspection, when we checked these records, we found they were very variable and some still had lots of gaps. For example, for a person confined to their room, their care records showed staff were supposed to to sit and have coffee with the person each morning. This was for social interaction and to reduce their risk of isolation. Their activity record showed this took place daily between first and twelfth of January 2017 but not since. As the person's daily food/fluid charts were also poorly maintained, we were unable to confirm whether or not that person received their morning coffee or the staff interaction each day. For two other people we looked at we also found very few entries in their activity records. Two staff had no concerns that anyone in the home was isolated, because they said staff spent time regularly with each person. One person came down each day after lunch with a staff member for a coffee and a cigarette. The other person preferred to remain in their own room, so they went up and had a chat with them, even though these activities visits were not always documented.

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

The complaints log showed five complaints had been raised since we last visited the service. In response to a care complaint from a relative, the deputy manager investigated the complaint, by speaking to the people and staff involved and documented the actions taken to address them. Three of the five complaints were about attitudes of two staff. Both were dealt with through one to one supervision meetings with the staff concerned. However, when we checked those staff files and earlier complaints, we found other people and staff had made similar complaints in the past about both staff members. For example, in one staff file, similar issues to those recently raised had been reported on five occasions previously going back to 2012. Each time they occurred, they were dealt with in a similar way. This meant no further action was taken, although the concerns had recurred. This showed the complaints process wasn't fully effective in tackling issues about staff attitudes.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records were easier to navigate, information was accessible and older information had been removed and archived. Details of each person's medical history were obtained. There were care plans about each person's communication, personal care, night time support, continence care, and health needs as well as instructions for staff about how to support people with oral health, nutrition, hydration and with their dietary requirements. Review dates showed care plans were reviewed and updated regularly. People's records had more person centred details about each person, their likes and dislikes, and about their life before they came to live at the home.

Some people's medical care plans showed what was being done about individual health needs and were reviewed monthly. For example, that a person had been seen by a physiotherapist to try and help them improve their mobility. Other care plans showed staff working with other health professionals about a person's nutritional needs, such as keeping a three day food and drink diary at the request of the community nurse. For another person, who hadn't much appetite and lost weight, staff were instructed to offer the person regular snacks and nutritional supplements and they were slowly gaining weight.

A ' My personal profile' included more person centred details about the person. For example, whether the person needed support with their communication, and was able to use the call bell for assistance, and measures to check on the person regularly if they were not able to summon help. Other details captured included individual preferences such as preferred time a person liked to get up and go to bed and details of anything that worried, frightened or upset the person and details of how staff could reassure the person. A life story book captured personalised information about each person, their life and circumstances before they came to live at the home. Staff knew about people's likes, for example, that one person liked to watch 'University Challenge' and another liked their radio tuned to 'Classic FM.' People's care plans included details about how each person wanted to be supported. For example, for a person who experienced anxiety, their care records said, 'Calm me, I like people to listen to me.'

Each person had a named member of staff referred to as a keyworker, who was responsible for ensuring people's care needs were met, supporting them with activities and spending time with them. They were also responsible for reviewing and updating people's care plans with them. A person recently admitted to the home confirmed staff consulted and involved them in developing their care plan. People who were able to, signed to confirm staff involved them with their care planning and in reviews of their changing needs, although some people did not recall their involvement. Where appropriate, records showed families were consulted and involved in people care and with best interest decision making for people who lacked capacity.

An medical care plan was used to identify new health care needs and instruct staff about the person's changed needs. For example, working with health professionals regarding the care of a person with a chest infection.

People told us about the activities available in the home, one said, "I can join in if I want to" and another said, "They play bingo, I try to join in. They will come up to my room and say are you coming down." Another person said they occasionally went out on a bus trip. A weekly activity plan included external entertainment such as musical entertainment and a range of activities organised by care staff. For example, an exercise class on Monday, a word quiz Tuesday morning and bus trip in the afternoon, a pub quiz on Wednesday. Other activities included a weekly 'knit and natter' group, film and supper on Saturdays and a Sunday mobile shop, where people could purchase toiletries, sweets and snacks . A senior member of staff was responsible for leading on activities and was working with other staff to ensure the activities happened each day. Posters and individual activity programmes made people aware what was on offer, and staff reminded people each day. On the day we visited, the planned quiz was cancelled as several people were unwell and

instead, staff did one to one word search puzzles with people who wished to participate.

The provider had a complaint policy and procedure and a complaint log was kept." People and staff mostly identified the deputy manager as the person they would go to in the first instance if they had a concern. One person said people were asked at residents meetings if they had any complaints or concerns, which they thought was an "excellent idea." A staff member said, "If you need anything or anything is bothering you, she will do her best to sort it out."

Requires Improvement

Is the service well-led?

Our findings

People said they were happy living at the home and with the quality of care received. One person said, "They are very good to us, I don't think it could get much better. Another said "All very kind and helpful, nothing outstanding, but there is nothing I need that I haven't got." A health professional said staff appropriately referred people with health needs to them and followed any instructions about their care. They also gave us positive feedback about staff interactions with people who lived at the home. People and staff praised the deputy manager, one person said "[Staff name] is easy to talk to." Another said, "I feel she has a lot on her plate, she is very helpful, always seems to be free to have a chat."

At the August 2016 inspection, we found some of the quality monitoring systems were not fully effective because they did not identify the two breaches of regulations found at the inspection. For example, they had failed to identify the environmental concerns about hot water temperatures, a lack of legionella controls, absent or broken window restrictors and gaps in people's individual care records.

As part of the improvement plan, a member of the local authority quality monitoring team visited the service on 6 October 2016 and helped the service with improving their quality assurance processes. For example, to develop a service improvement plan and to improve the quality monitoring systems. The quality monitoring team recommended all care plans should be regularly reviewed and updated. On the 12 December 2016, they revisited the service and reported on improvements made in personalising care records to make them more specific to individuals, and recommended further development in this area. They also recommended a summary page, so staff could see 'at a glance' people's main needs, which has since been developed.

At this inspection we found improvements had been made in the quality monitoring systems at the home. However, these were still not fully effective, because a continuing breach of regulation was identified at this inspection. We found some increased risks for people, in relation to accuracy of record keeping. The registered manager undertook a monthly audit of care records which involved sampling four set of people's care records. However, the absence of care plans for people with diabetes, gaps in food/fluid records and in daily care records had not been identified or addressed. This meant the care records audit was not fully effective in making ongoing improvements. They also undertook an audit of people's activities each month and had identified areas of concern regarding some people not having a high level of activities, which increased their risk of isolation. However, it was not clear how these concerns were fed back to staff. Two staff we spoke with were not aware that people had been identified as requiring more activities.

None of the staff could recall when a staff meeting was last held at the service and no minutes were available. The deputy manager recalled that previously when staff meetings were arranged, they were poorly attended. In the absence of staff meetings we could not ascertain how staff were involved in changes and decision making. When we followed this up with the deputy manager, they said normally they told staff about changes as they saw them and wrote a memo which they left in the staff office, for staff to read. We did not think these methods were effective in communicating and engaging with the staff team in maintaining and embedding the improvement plans.

We also identified concerns with regard to how complaints about individual staff performance were managed. Where similar concerns about staff attitudes were raised again, they were dealt with in a similar way but no further follow up action was recorded. When we checked the service grievance and disciplinary policies it said where concerns about individual staff persisted, formal disciplinary and capability procedures should be instigated but hadn't been. This showed people remained at risk because the policy was not followed, and staff conduct issues were not robustly dealt with.Furthermore, the audit of complaints should have picked up these issues and addressed them.

A director in the company visited the home regularly, most recently on 20 December 2016. During their visit they sought feedback from people, visitors and staff who reported they were happy with the home and felt able to raise concerns. They also checked the environment and the grounds. However, opportunities to identify other gaps in quality monitoring systems were missed.

This inspection is the third successive Care Quality Commission inspection in which a breach of regulations has been identified. Risks for people remain in relation to record keeping and staff conduct issues and a failure to engage the wider staff team in making the required improvements. These findings demonstrate the quality assurance systems at Elmwood were still not fully effective, because all reasonable actions were not being taken to minimise risks to their health, care and welfare.

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

At Elmwood the registered manager also has the role of the responsible person; the person nominated to act as the provider's main point of contact with the Care Quality Commission. Although not against the regulations, CQC's registration guidance recommends separating those roles in small services, so they can benefit from external scrutiny. The director who managed Elmwood lived abroad but visited the home regularly. The deputy manager said they were in regular contact with them and could also access a UK based director in the company, who worked at a nearby home.

When we visited, the registered manager was on planned sick leave. In their absence, the provider had notified the Care Quality Commission the deputy manager was in charge of the day to day running of the home. On the day we visited, the deputy manager was stretched undertaking these extra responsibilities in the absence of the registered manager. Although they remained calm and professional throughout, they were leading the staff team, taking calls, dealing with health care professionals, people, visitors and managing the CQC inspection. We asked the deputy manager whether they had been freed up from any of their responsibilities, in order to cover the registered manager's duties. The deputy manager said they hadn't and were carrying out both roles. They commented it was difficult to get staff to volunteer to take on extra responsibilities but said one senior care worker had taken on extra responsibilities relating to medicines management and activities since the last inspection. The deputy manager said they worked closely with the registered manager. They shared an office in the centre of the home and operated an 'open door' policy. People, staff, relatives and professionals came into the office regularly to ask questions, share information and raise any concerns.

Three senior care staff who took charge of the staff team on each shift, and allocated staff their duties using an allocation sheet. A written handover sheet was used to record and communicate key changes in people's care needs between staff. At daily handover, information about changes to people's care were communicated between staff.

The service was using several new audit tools recommended by the local authority quality monitoring team.

A manager's monthly checklist had been developed to check various aspects of the service including fire safety, checks of equipment, such as bedrails and bumpers and pressure relieving equipment as well as more thorough checks of environmental safety.

Residents meetings were held where the views of people were sought about the food, activity programme and about whether people had any concerns or grumbles. No surveys seeking the views of people/families about the home had been undertaken since we last visited.

A training matrix was used to monitor that staff attended all the training and updating required for their role. Although some people's training was overdue, update training was planned later in the year. The deputy manager outlined improvements made in end of life care, through working in partnership with the hospice nurse.

The CQC rating poster about the last CQC inspection was on display in the main entrance, and on the home's website, with a link to the summary report in the staff office and reception area, no summary report of the most recent inspection report was available, although copies of previous inspection reports were seen. When we explained to a staff member why CQC inspectors were carrying out another inspection, two staff said they were not aware of the findings of the previous inspection. The deputy manager said they had been available previously. After the inspection, they contacted us to let us know they had subsequently located a copy in the kitchen and arranged for further copies to be made available.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. Regular statutory notifications were received from the service. This enabled us to ensure we were following up and addressing any potential areas of concern.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints People were at increased risk because complaints about staff were not dealt with robustly enough to prevent similar complaints recurring. This is a breach of regulation 16 (1) (2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance People were not fully protected because the quality monitoring systems in place were not always effective. Issues about staff attitudes had not been robustly dealt. There were still some gaps in people's care records which increased the risk people would not receive all the care they needed. This is a breach of regulation 17 (2) (a), (b), (c), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a warning notice