Mr Sariff Jomeen

West Bank Care Home

Inspection report

21 Crow Tree Lane
Bradford
West Yorkshire
BD8 0AN

Tel: 01274487889

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected West Bank Care Home on 24 and 30 March 2016 and the visit was unannounced. Our last full inspection of this service took place in June 2013. At that time, we found the provider was not meeting the regulations in relation to staffing and safe management of medicines. We took enforcement action and made two further visits to check that improvements had been made.

West Bank Care Home is a privately owned care home for adults who are living with a mental illness. The home is registered to carry out the regulated activity accommodation for persons who require nursing or personal care. Nursing is not provided. The home is registered to accommodate a maximum of ten people. There are eight bedrooms, one of which is shared. There is a dining room and lounge on the ground floor and a communal bathroom on the first floor.

At the time of our inspection the person managing the service was not registered with the Care Quality Commission.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People who used the service told us they felt safe with the care they were provided with.

We found the home had not been maintained safely and standards of décor, furnishings and cleanliness were poor. For example there were no window restrictors in place, water at several outlets was running at a temperature which could have caused scalding and the call system was not working. Several areas of the home were not clean. We found this was a breach in regulation as the premises were not clean or well maintained.

Systems for managing medicines required some improvement as there were no protocols in place fro medicines prescribed on an 'as required or PRN basis. We found this was a breach in regulation.

Recruitment processes were robust and checks were completed before staff started work to make sure they were safe and suitable to work in the care sector. Staff told us they felt supported by the manager and that training opportunities were good. However we found staff had not received practical training in moving and handling people. We found this was a breach in regulation.

We found staff friendly and helpful and there was a nice atmosphere in the home. People who lived at the home told us they liked the staff.

We found the poor environmental standards demonstrated a lack of respect for the dignity of the people who lived at the home. We found this was a breach in regulation.

There were enough staff on duty to make sure people's care needs were met and people were able to follow their choices in their daily routines.

We saw little evidence of people being supported in engaging in independent living skills

People had access to healthcare services as they were needed.

We found the service was meeting the legal requirements relating to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People who lived at the home and staff spoke positively about the manager who was described as supportive and caring. We found them to be knowledgeable about their role. However, although some quality assurance systems were in place, the systems were not effective as they had failed to identify and rectify the significant issues we found at this inspection. We found this was a breach in regulation as there was not good governance.

Overall, we found significant shortfalls in the service provided to people. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

The home was not maintained in a way that would maintain the safety of the people living there.

The home was not clean and effective infection control procedures were not in place.

Improvements were needed to management of medicines.

Staff were recruited safely and there were enough staff available to meet the needs of the people living at the home.

Is the service effective?

Requires Improvement

The service was effective but some improvements were needed.

Staff received training but this was mainly on line and staff had not received practical moving and handling training.

Staff were supported by the manager.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People enjoyed the food at the home.

Records showed people had regular access to healthcare professionals, such as GPs, opticians, community nurses and dentists.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff demonstrated a caring approach and respected people's privacy.

People's dignity was not always considered and respected.

Little was in place to support people in independent living skills.

Is the service responsive?

Requires Improvement

The service was responsive but required some improvement.

Care plans gave good information but lacked evidence of a person centred approach.

People were able to follow their own routines and engage in activities of their choice.

Complaints were managed well.

Is the service well-led?

Inadequate

The service was not well led

There was a lack of effective governance systems to monitor and improve the quality and safety of the services provided.

The manager has systems in place to gain the views of people who lived at the home.

West Bank 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 24 and 30 March 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. On this occasion we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with six people who lived at West Bank Care Home, the owner, the manager, two care workers, a cleaner and a community mental health nurse.

We spent time in the dining room speaking to people and looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; four people's care records, three staff recruitment files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

On the first day of our inspection we completed a tour of the premises. We found the premises to be unclean and unsafe in a number of areas. The kitchen was situated in the cellar. We found the food preparation surfaces, the cooker, the inside of the fridge, cupboards and drawers and pans and cutlery stored in cupboards to be unclean with visible grease and food debris.

We saw the main dining room to of a kitchen/diner design including a fridge, dishwasher and hob. Staff told us the dishwasher and hob did not work and the hob was not required as all food was cooked in the cellar kitchen. We saw the fridge door did not close and the inside of the fridge was dirty. Items such as meat paste and milk were being stored in the fridge. The surfaces, fronts of drawers and cupboards and the floor were dirty. When we tried to open some drawers they found they were broken. We found cereals stored in dirty Tupperware boxes which were not closed.

In the main lounge we saw the furniture was stained and dirty. We saw a large area in the corner of the room covering part of the ceiling and part of the two adjoining walls had been affected by damp and was unsightly. We found the gas fire in this room was not working and were told it had been disconnected.

In the communal toilet on the ground floor we saw the sealant around the base of the toilet was missing and that the exposed concrete flooring was affected by urine.
In one bedroom we saw the base of the bed, with integral drawers to be heavily stained. The care manager told us this was due to the occupant urinating in the drawers. This was still evident when we returned to the service six days later.

We found bedding and pillows to be dirty and stained in some of the bedrooms.

In the bathroom on the first floor we found the bowl and base of the toilet to be badly cracked. We also found the communal toilet adjacent to the bathroom to be cracked in the same way. The washbasins in both facilities were also badly cracked. This meant the toilets and washbasins could not be cleaned effectively and posed an infection control risk.

We found the plug to the bath did not fit which meant people living at the home would not be able to run a bath. There was a shower attachment to the bath taps. However when we tried to turn on the shower only a small trickle of water came from the shower head with some water running from the tap. As this was the only bathing/shower facility in the home we concluded that people living at the home would not be able to take a bath or shower to meet their personal hygiene needs.

We saw floor coverings were in some areas were dirty, stained and of poor quality. On the first floor landing the carpet was ill-fitting with exposed gripper strips. Both the gripper strip and the trip hazards posed risks to people. Also we found directly outside bedrooms on the ground floor, the floor had sunk causing a trip hazard.
We found some doorframes were in need of repair with exposed broken architrave posing a risk to people.

We saw none of the radiators were covered or of a cool panel design. We found some radiators very hot to touch. Furthermore we took temperatures of hot water taps serving baths and wash-basins. Whilst we saw thermostatic monitoring valves in place we found water temperatures above 53 degrees C at two washbasins and at 50 degrees C in the bath. In both washbasins there was no plug available which meant people would have to wash under running water. These observations showed the provider was not taking adequate steps to protect people from the risks associated with hot surfaces and hot water.

All of the first floor bedrooms had large windows which did not have restrictors in place. Narrow pieces of wood had been fixed to the window frames going across the bottom part of the windows. However these were low level and would not prevent a person falling from the windows. One person showed us that their bedroom window did not close and told us they were cold when in the room.
We told the provider immediate action must be taken to address the safety of these windows and a joiner was called to the premises.

On the first day of our inspection we checked the call buzzer from one of the bedrooms. No staff responded to the call. We went to the dining room and asked the manager to press call buzzers in other areas. We found none of the buzzers were working. This meant people living at the home or staff were unable to summon help in the case of emergency.

We saw the back door to the home was in a very poor state of repair with pieces of wood missing. We also saw the door did not fit into its frame properly and therefore could not be locked. The door led into a porch with a second door leading into the main house. We asked staff if there was a lock on the secondary door and they told us there was not. This meant the building could not be secured and could be accessed at any time.

On the second day of our inspection we found some cleaning had taken place and the provider had arranged for the call system to be repaired. However, we concluded this action would not have been taken if our inspection had not taken place.

We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date. However, the provider and manager were not able to locate the five year electrical installation certificate. The manager said they would email this to us after the inspection visit. This had not been received after seven days and when we telephoned the home to ask about it, the manager told us it was out of date and arrangements had been made for an electrician to visit the home. We asked to see the certificate and found it was over nine months out of date. This meant the provider could not be assured that the electrical systems in the home were safe

This meant the provider had failed to mitigate environmental risks or to make sure effective infection control procedures were followed.
This demonstrated a breach of Regulation 12 (2)(d) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected medication storage and administration procedures in the home. Oral and some topical medicines were administered to people by trained care staff. We found no people had chosen to administer their own medicines. Care plans recorded this fact. Where it appeared people may not have the mental capacity to make choices about who should administer their medicines we found no evidence of specific mental capacity assessments.

The application of prescribed barrier creams was recorded on the medicine administration record (MAR)

and on a body map chart co-located with the MAR sheet. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We found medicine trolleys and storage cupboards were secure, clean and well organised. However the metal medicine storage cupboard was wall-mounted directly above a radiator. The temperature at which medicines were stored was not recorded and whilst the radiator was not hot during our visit we found the storage facility did not provide the right environment in which to store medicines.

As necessary (PRN) medicines were not supported by written instructions which described situations and presentations where PRN medicines could be given. The absence of a protocol falls short of the guidance given by the National Institute for Health and Care Excellence (NICE) and increases the risk of inconsistencies in administration.

This demonstrated a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a random sample of three medicines dispensed in individual boxes. On all occasions we found medicines were correctly accounted for.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs. At the time of our inspection no people were prescribed controlled drugs. We also found no people were prescribed a medicine which required storage in a fridge. However, we found no facilities existed to store controlled drugs or the provision of a medicines fridge. We were told this requirement had not been needed in the past. We asked the manager to develop a contingency policy to allow medicines to be correctly stored.

We noted the date of opening was recorded on all liquids and creams that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis.
We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure staff had the advice and guidance they needed to safely administer medicines. However we found the policy needed to be updated to reflect the most up-to-date guidance. For example, the policy referred to outdated requirements of the Care Quality Commission (CQC).

Our observations of the medicine round showed medicines were administered with sensitivity. Our scrutiny of the MAR sheets and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed.

People living at the home told us they felt safe. One person said, "Yes its fine here, much better than where I was before." Another person said, "The staff are lovely and will do as much as they can for me."

We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions.
We saw people had personal emergency evacuation plans (PEEPS) in their care files. The PEEPs contained up to date information on the support people would need to evacuate the home in case of emergency.
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We examined the procedures and practices regarding the handling of people's personal money. We found all people were assisted to manage their own money. On all occasions money was accounted for with

transparency. Money given to the acting manager was fully accounted for with receipts retained for all purchases made on people's behalf. Where people asked for cash a member of staff witnessed the person receiving their money and both they and the service user signed the accounting form.

Training records showed staff had received training in protecting vulnerable adults. All of the staff we spoke with demonstrated a good understanding of how to keep people safe and knew how to report any concerns they might have. Although staff were able to tell us about different forms of abuse, they were not always clear about what might constitute verbal abuse between people who lived at the home. The manager said they would revisit this with staff through supervision.
We saw accidents were recorded appropriately and although the manager told us they did not document any audit of accidents, they were aware of all accidents recorded.

Staff rotas showed that staffing levels were set at two staff between the hours of 8am and 9pm with one waking night staff. None of the people we spoke with raised any concerns about the staffing arrangements.

We looked at recruitment records for three staff working at the home. The files we looked at contained evidence pre-employment checks had been completed. These included disclosure and barring checks, references and checks of identity. This meant that safe procedures were being followed to make sure staff were suitable to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received good training and they could discuss their training needs with the manager during supervision. One staff member told us about a training need they had identified for themselves and the manager had arranged a course for them. Another member of staff told us they were studying for the National Vocational Qualification (NVQ) level three award in care.
The training matrix showed staff received training in areas including health and safety, medicine management, mental health, food hygiene and first aid. The acting manager told us training for protecting vulnerable adults had been sourced through the local authority but other than that we saw the majority of training was done either on-line or through 'Social Care TV.'

Two members of staff told us they had not received practical moving and handling training for over six years and another told us they had not received this training at all. There were no records available to show that any other members of staff working at the home had received this practical training. We saw from care records that one of the people living at the home needed support with moving and handling and it was therefore important that staff received training on how to do this safely.

This demonstrated a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff new to the service followed a short induction to the home.

Staff told us they received supervision with the manager every two months and we saw records which confirmed this. However we saw the manager had not received supervision from the provider or any person acting on their behalf for several months.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager confirmed none of the people living at the home had DoLS authorisations in place. The information we saw in care plans showed all people had the mental capacity to make their own decisions. A discussion with the manager about each person showed there to be a potential for the need to consider DoLS in the medium term. Some people had a diagnosis which may affect their cognitive ability and there already existed evidence some people had fluctuating capacity with loss of short term memory. Furthermore

some people recognised they needed support to safely venture into the community. Our discussions with the manager showed they fully understood the requirements of the MCA and DoLS and knew how to apply their knowledge should the need arise.

Our review of care files and a discussion with the manager showed some people were without any family or close friends. We saw on two occasions people had accessed advocacy services in the past to help them make decisions about their care. We saw no evidence of any other advocacy input since November 2011 yet care planning reviews had taken place every six months. The manager assured us they would review the need for appropriate people to be made aware of advocacy support.

People spoke positively about the quantity and quality of the food. One person said, "The food's very good; three meals a day and we can make a cup of coffee when we like." Another person said," Yes the food is good and plenty of it, we can also help ourselves to fruit." We saw a bowl of fresh fruit was available and people accessed this freely.

On the second day of our visit we saw the fridge in the dining room had been labelled as not working. Milk was being stored in the fridge in the cellar which people who lived at the home did not have access to. This meant people were not able to make a drink without asking staff.

People received varied and nutritious meals including a choice of fresh food and drinks. Staff were aware of people's likes and dislikes and offered alternatives if people did not want the menu of the day. One person chose to eat out on occasions but they said this was just for variety rather than a dislike of food provided. All people were able to eat independently. The lunch time experience was a calm, relaxed and social occasion when most people came together to eat. We saw nutrition and fluid intake records were in place for one person assessed as nutritionally at risk. We saw all people participated in a washing-up rota after every meal. We spoke to the person who was washing up on the day of our visit, they said, "I like to wash up and do things for myself so that one day I might be able to look after myself."

Records showed arrangements were in place that made sure people's health needs were met. We saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community mental health nurses, social workers, specialists in learning disorders and dentists.

Many people at the home were diagnosed with a severe mental disorder, were at risk of harm, may tend to neglect themselves and had a history of having being detained under the Mental Health Act 1983. As such some people's care was coordinated under a Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw CPA meetings took place with all relevant health and social care professional in attendance.

Requires Improvement

Is the service caring?

Our findings

Staff we spoke with demonstrated a good knowledge of the people living at the home. They knew their care needs and demonstrated a caring and supportive approach.
We observed staff and people in communal areas and noted there to be a calm and settled atmosphere. This helped people who had identified problems with anxiety which could result in aggressive and disruptive behaviours. Staff spoke quietly and gave encouragement for people to participate in conversations.

During our inspection tour of the property we noted staff respected people's privacy by knocking on doors before entering people's rooms. However we saw privacy curtains were not in place in the shared room. The acting manager told us this was the choice of the people who occupied the room. However we considered this choice was limited by there not being any privacy curtains available.

We were concerned that people's dignity was not always considered. For example over the two days of our visit we found people's beds made with dirty bed linen, bedroom furniture to be in a poor state of repair, carpets and other furniture used by people who lived at the home stained and dirty and a lack of appropriate washing and bathing facilities.

Although some of these issues had been addressed between our visits we found this had not always been done in a way which demonstrated a respect for the people living at the home. For example, we had pointed out that one person's bedroom furniture was in a poor state with handles missing which made it difficult for the person to open their drawers. On our second visit we saw the provider had put handles on which did not, in any way, match either the furniture or the existing handles. In another person's room we saw no action had been taken to address the urine stained bed base. In the bathroom a new plug had been put in place so that a bath could be run but no action had been taken to address the shower attachment not working. We concluded that the actions taken had been in response to our findings rather than a respect for the people who lived at the home.

This demonstrated a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people who lived at the home took turns in washing up after meals and one person told us they liked to do things for themselves so they might be able to look after themselves one day. However, other than washing up we saw little evidence of people being supported in engaging in independent living skills. For example there were no facilities available to support people to do their own cooking.

Requires Improvement

Is the service responsive?

Our findings

Care plans provided comprehensive information about how people wished to receive care and support. Staff confirmed the care plans provided all the information they needed to care for people appropriately and enable them to meet people's needs. A health professional we spoke with at the home told us "The care assessments are good here and I have no difficulties understand what is going on."

We saw care records included details of people's previous medical histories, life histories and pen picture of their lives. Record had been made of the person's interests, their family and friends and any dates that were important to them. Detailed care plans were in place for needs including physical health, mental health, nutrition and personal safety which gave staff good detail of the support people needed to meet their needs safely and in the way they preferred. We saw some evidence of people having been involved in their care planning and having signed their own care plans. We spoke with one person to ascertain their understanding of what they had signed for. Their answer confirmed they had a good understanding of their care package.

Other people's care records included information about them not wanting sign their individual care plans but had signed to evidence their involvement in six monthly care plan reviews and an annual review of their care and support with the manager and care manager.

Whilst care records included some detail of people's lifestyles and preferences, they did not always demonstrate a wholly person centred approach. For example, reviews of care and support plans had been completed by staff on a regular basis but did not demonstrate what, if any, action had been taken to involve the individual concerned in the review. We discussed with the acting manager ways in which a more person centred approach could be employed and demonstrated through care records.

We saw people followed their chosen daily routines. For example people watched television in their rooms, listened to music or went out to shops and cafes of their choice. The manager showed us a programme of activities available for people who chose to stay in the home to join in with if they wished. We saw photographs of outings taken by the people who lived at the home and staff to places of interest.

The complaints procedure was on display in the dining room and we saw records to show that people who lived at the home had used the procedure. Records showed that when people had raised a complaint, it had been investigated and the findings of the investigation recorded. The records also showed how the complaint had been resolved.

Inadequate

Is the service well-led?

Our findings

The home had a manager who was present on both days of the inspection. The provider was present for feedback on both days.

We saw a 'Quality Assurance Daily Checklist' was in place. This included a number of areas relating to the environment for staff to sign to say they had checked and for them to record any issues. The list included checks on fridge and freezer temperatures, condition of people's bedrooms and general cleanliness of the home. We looked at the daily checklist going back over a period of two months and saw staff had completed it without raising any issues. We also saw an infection control audit had been conducted by staff two months prior to our inspection with no issues identified.

On the first day of our inspection we found a number of concerns relating to the safety of the service, the standards of hygiene and poor standards of furniture, fixtures and fittings and washing and bathing facilities. None of these issues had been documented on the daily audit checklist.

We saw staff had made note of some environmental issues in a repair book but saw these had not been addressed to ensure the comfort and safety of the people living at the home. We saw note had been made of the dining room fridge not working six months prior to our inspection, problems with the call system dating back over four years, poor state of kitchen cupboards dating back over two years, damage to the lounge wall dating back over two months and the window not closing in a person's bedroom had been recorded twice dating back almost four months from the date of our inspection.

On the first day of our inspection we told the provider they must take urgent action to address a number of safety issues within the home.

When we returned six days later we found the provider had responded to some, but not all, of our concerns. Action had been taken to make windows safe, an engineer had been called to look at the call system and staff told us there had been large amounts of cleaning taking place. However, hot water temperatures remained at levels which could cause scalding and other safety and maintenance issues identified through this report had not been addressed.

We asked the provider if they had conducted any quality monitoring of the service, they said they had not. We found there was no formal system for the acting manager to raise issues about the service with the provider.

We found the provider had failed to provide necessary personal protective equipment for staff to wear to reduce the risk of the spread of infection within the home. We saw records which showed two people who lived at the home were buying disposable gloves for staff to wear when providing their personal care. We asked the acting manager about this and they told us the provider bought the gloves using the personal money of the people concerned. When we asked the provider about this they said they did not get gloves supplied free of charge and therefore thought it right to have the service user pay for them. Care plans for

the people concerned showed they had care needs for which staff would need to wear disposable gloves.

This demonstrated the lack of effective governance systems to monitor and improve the quality and safety of the services provided and to mitigate risks relating to the health, safety and welfare of service users and others. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager demonstrated a good knowledge of accidents and incidents that happened within the home and had managed complaints well. However there was no documented system of audit of records.

We saw the manager held regular meetings for people who lived at the home and for staff. We saw people had the opportunity to raise issues or to make suggestions during these meetings. We also saw that people who lived at the home were asked for their feedback about the service they received. All of the feedback we saw was positive.

All of the staff and people who lived at the home we spoke with gave positive feedback about the manager and we found them to be knowledgeable about their role and responsibilities. We also noted that although the manager had not received supervision from the provider, they had demonstrated their wish to reflect on their practice by arranging supervision for themselves with the care manager acting as supervisor.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received all the training they needed to make sure people's needs were met safely

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to make sure the environment was safe and that effective infection control procedures were followed. Protocols for managing PRN medicines were not in place.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

The enforcement action we took:

Warning notice