Finest Care Limited

Clifton House Residential Care Home

Inspection report

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25 February 2016
29 February 2016

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 22, 25 and 29 February 2016 and was unannounced. We last inspected the home on 22 September 2015 and found the registered provider had breached the regulations for managing medicines. Following the inspection we issued a warning notice to the registered provider.

Clifton House Residential Care Home is registered to provide nursing or personal care for up to 28 people. At the time of our inspection there were 25 people living at the home, some of whom were living with dementia.

The home had 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.

During this inspection we found the registered provider had breached regulations 9, 17, 18 and 19 of the Health and Social Care Act 2008. We found there were not always enough staff deployed to ensure people received the care they needed in a timely manner. Staff had not received regular one to one supervision with their line manager. Some training and appraisals were also overdue for all staff. The registered provider had not followed safe procedures when recruiting new staff to ensure they were suitable to work with vulnerable adults. People living with dementia did not always receive personalised care to meet their specific needs. In particular, staff had not completed in-depth training in dementia awareness and adaptations had not been made to help promote people's independence. There was a lack of meaningful engagement and stimulation for people with no activities being provided. The environment was not suitable for people living with dementia. Needs assessments and care plans had been completed without the involvement of people using the service or family members who knew them well. Care plan evaluations were overdue for all care plans that we viewed. Opportunities for people or family members to give their views had lapsed. Audits and checks to ensure people received safe and appropriate care were overdue. This included analysing falls in the home, which had increased since January 2016.

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

We found during this inspection the registered provider had met the requirements of the warning notice issued following our last inspection. We viewed a sample of medicines administration records (MARs) and topical cream charts. We saw these were usually completed accurately with only minor gaps in signatures identified. Stocks of medicines were kept securely and safely in locked medicines cupboards and trolleys.

People and family members gave us good feedback about how kind, caring and considerate the staff team were. They said staff tried their best to meet their preferences, however this was currently difficult due to the current staffing situation within the home. Where people did receive interaction from staff this was always done with affection and kindness.

Staff had a good understanding of safeguarding adults and whistle blowing, including how to report concerns. They said they would feel able to raise concerns. One staff member said, "Yes I would raise concerns." Safeguarding referrals had been made to the local authority safeguarding team in line with the home's agreed safeguarding procedure.

Records showed some health and safety checks were not up to date, such as the fire risk assessment, fire drills, legionella survey and the electrical installation safety certificate. However, the registered manager told us these had been updated. Other checks were up to date including checks of gas safety, fire detectors and fire alarms. Personal emergency evacuation plans (PEEPs) had been completed for each person.

Although the home was clean, we saw there was unfinished maintenance work around the home which had been marked with large white crosses. The registered manager told us the maintenance person was catching up with the outstanding work.

The registered provider followed the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS authorisations had been made to the local authority where required. Staff asked people for their permission before providing care.

We observed over the lunch time and saw people were regularly left unsupervised as staff were busy. Although most people were independent with eating and drinking, those people requiring support did not always receive this in a timely manner.

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. There were not enough staff deployed to ensure people received the care they needed in a timely manner.

New staff had been recruited without the required recruitment checks having been carried out first.

Staff knew how to report safeguarding and whistle blowing concerns.

Some health and safety checks needed updating and unfinished maintenance work needed completing.

Is the service effective?

Requires Improvement

The service was not always effective. Staff one to one supervisions and appraisals were overdue for all staff. Staff had not completed all of the training they required.

Care for people living with dementia needed to be improved. There was a lack of meaningful engagement and stimulation for people.

The registered provider followed the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not always caring. Staff did not have time to give people one to one time when they needed it.

People gave us good feedback about their care.

People and family members told us staff were kind, considerate and caring.

Is the service responsive?

Inadequate

The service was not responsive. People or family members had not been involved in needs assessments to ensure each person's

individual needs were met.

People had not been involved in developing their care plans. Care plans were not up to date as evaluations were overdue.

There were no activities provided for people to take part in.

Some family members told us their concerns were not being dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led. The registered manager had not assessed the impact of staffing levels on people using the service or staff following the admission of 14 people in January 2016.

There were only limited opportunities for people or family members to give their views about the service. Quality assurance audits and checks were overdue.

There had been no falls analysis carried out despite a recent increase in the number of falls in the home.

The home had a registered manager. Statutory notifications had been submitted to CQC as required.

Clifton 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 22, 25 and 29 February 2016 and was unannounced.

The first visit to the home was carried out by two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The subsequent visits were carried out by one adult social care inspector.

We reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We spoke with 12 people who used the service and three family members. We also spoke with the registered manager, two senior care assistants and two care assistants. We observed how staff interacted with people and looked at a range of care records. These included care records for three of the 25 people who used the service, nine people's medicines records and recruitment records for five staff.

Inadequate

Is the service safe?

Our findings

Following our last inspection in September 2015 we issued a warning notice to the registered provider as they had continued to breach the regulation for managing medicines safely. We found during this inspection the registered provider had met the requirements of the warning notice.

Medicines were kept securely in locked cupboards and locked medicine trolleys. Medicines were stock controlled on a weekly basis, with running balances recorded on the medicine administration record (MAR). We saw dates had been written on boxes of medicines to indicate when they were first opened. One senior support worker told us, "We put the date on the box or bottle so we make sure the medicine is only used for a certain time. Eye drops have to be used in a certain date."

Senior staff were able to explain in great detail how medicines were managed in the home from ordering to returning medicines. The service had an interim medication tracker system for each person, which recorded the date medicines were ordered, when they were delivered and when they were returned, if appropriate.

Only senior support workers and the registered manager administered medicines. Certificates were available to show staff had received training in the safe handling of medicines. One senior support worker told us, "The registered manager comes around with me and watches me do medications." However, there were no records available to us to demonstrate this.

We observed people receiving their medication in a timely manner, including medicines liable to misuse (controlled drugs). We checked seven MARs dated from November 2015 to February 2016. We saw records were usually completed correctly. However, we found a small number of missing signatures where staff had not signed to confirm medicines had been given. We found no evidence these had been identified and investigated prior to our inspection.

People received topical medicines when they were due. Where people were prescribed topical creams, their MAR stated, "see topical files." Topical files were kept in people's rooms for ease of recording by staff. We sampled four files and found them to be signed correctly. One staff member told us, "We now have plans in place for applying creams, with information where to apply the cream and care staff sign every time. The pharmacist gave us guidelines."

During this inspection we found further breaches of the Health and Social Care Act 2008. The registered provider could not be certain new staff were suitable to work with vulnerable adults. This was because new staff were not recruited safely as the registered provider had not followed the agreed procedure. The registered manager told us the recruitment procedure required prospective new staff to have two references and a current disclosure and barring service (DBS) check before being employed. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people.

We viewed the recruitment records for seven recently recruited staff. The registered provider had not

received and requested two references for each staff member. Of the seven staff files we viewed four did not contain the two references. DBS checks had not been carried out for two new staff and DBS checks were out of date for three new staff. Where criminal convictions had been declared on DBS records, there was no record of a risk assessment having been carried out to check the new staff member was appropriate to work with vulnerable people. The registered manager told us she would have a conversation with the staff member but this would not be recorded anywhere.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was unable to provide evidence that sufficient staff were deployed to ensure people's safety and wellbeing. The registered manager told us the number of people using the service had increased from 14 to 28 over a short period of time in January 2016. Due to the increase in admissions staffing levels had increased by one additional staff member. The registered manager was unable to provide us with any documented information about how this number had been determined. They also confirmed there had been no assessment of people's needs or a risk assessment carried out to consider the impact of the staffing situation on people. We found the dependency tool used to assess staffing levels had not been used since November 2015. We asked the registered manager about staffing levels in the home. She replied staffing levels were "fine after 10 o'clock when everyone was up."

Throughout our inspection we heard nurse calls were continually being activated by people. Staff had to respond to these calls placing people at an increased risk, due to being left unsupervised in communal areas. We found no evidence an audit of nurse calls had been carried out since the additional 14 service users had moved in. This meant the registered manager had not assessed the impact the amount of staff time was spent answering nurse calls and the potential risk of people being left unsupervised. We observed people were regularly left unsupervised in communal areas as staff endeavoured to answer people's 'nurse calls'. For example, we carried out an observation in the communal conservatory between 6.15am and 9.15am. We saw staff were absent from the room for the majority of this time.

We also saw when staff were in the conservatory they did not have the time to help people. For example, one person asked on three occasions, when a staff member checked into the conservatory, "What have I got that I can do." On each occasion the staff member responded, "You can stay there and we will have breakfast in a bit." On another occasion a person asked a staff member "What time will we get one [a cup of tea]." The staff member responded, "At 10 o'clock when Susan brings it." We observed at other times of the day people being left unsupervised for long periods. Some people were confused and kept trying to get up, whilst other people were trying to prevent them from doing so and calling for staff.

Staff we spoke with told us there were not enough staff to meet people's needs appropriately. One staff member told us staffing levels were "rubbish, it is a nightmare, the residents are much more needy now." They went on to tell us, "We are run off our feet, we don't get a break half the time. Some people ring when it is not urgent and some get left." Another staff member said, "It is very, very busy still. Sometimes you feel like you could do with extra help. It all depends on what the residents are like. We get a lot more buzzers going off." A third staff member said, "We could do with some more staff. It is busy all the time, we have residents who are more demanding. It would lessen the load."

Family members also said staffing levels were a concern. One family member said, "Since all the new residents came there isn't enough staff to cope, I've spoken to staff and they are really stressed with it all, they can hardly cope. The staff at night was only two, it's three now but hardly enough. The manager is retiring soon and there are staff leaving." Another family member said, "This place was exemplary up until

December but since this influx of new people I have real concerns. I am worried about the staffing levels and how busy and how tired the staff are. I went away on holiday in January and came back to an entirely different home."

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

Staff had a good understanding of safeguarding adults, including how to report concerns. They were able to tell us about various types of abuse and potential warning signs to look out for. All staff said they would report any concerns to the registered manager. We viewed the safeguarding log which showed three recent safeguarding concerns had been made. We saw the registered manager had followed the agreed procedure in notifying the local authority safeguarding team. At the time of our inspection these were currently in the process of being investigated.

Staff also knew about the registered provider's whistle blowing procedure including their responsibility to raise concerns. Staff told us they had never needed to use the procedure but would be confident to do so if required. One staff member said, "Yes I would raise concerns." Staff told us they were certain concerns would be dealt with correctly. One staff member said, "They would definitely be dealt with."

Some checks to ensure the safety and security of the building were not up to date. We viewed the health and safety records for the service. Gas safety certificates were in place and up to date, along with service records for other health and safety checks such as checks of fire detectors and fire alarms. We found that fire drill records were last completed December 2014. We also found the fire risk assessment and legionella survey for the building were well overdue for review, dated 2011 and 2013 respectively. The electrical installation in the health and safety file was not satisfactory with work required. The registered manager told us these had been updated. However, the records were not available to us during the inspection. Personal emergency evacuation plans were in place to guide staff as to people's support requirements in an emergency situation.

The home was clean and had no lingering odours. We observed domestic staff carrying out cleaning duties throughout our inspection. However, we observed unfinished maintenance work as we walked around the home. For example, there were half finished painting jobs all around the home which had been marked with large white crosses. The registered manager told us the maintenance person had been absent from the home but was now back and was catching up with outstanding work.

Requires Improvement

Is the service effective?

Our findings

We viewed the supervision and appraisal records for ten staff members. The records stated, 'care staff to receive supervision at least six times a year'. We saw the registered provider had not met this aim as none of the staff, whose records we viewed, had received the required number of supervisions. For example during 2015 most staff had received three one to one supervisions and an appraisal. We also saw that there had been no supervisions carried out since October 2015. We also saw appraisals were overdue for all staff.

We found that newly recruited staff had not received a structured induction into their caring role. The induction records we viewed consisted of a checklist of the various procedures operated in the home. We found no records of a more in-depth induction process having taken place for new staff. Induction records contained a section for staff to complete a 'one week review', only one staff member had received this weekly review.

We viewed the current training plan for the home which included training information for 25 members of staff. We found some essential training was out of date. For example, six staff members had not completed moving and assisting training, 19 had not completed first aid and 14 had not completed equality and diversity training. The deputy manager told us, "This was planned for January but due to the new admissions into the home we have put it on hold." A significant number of the recent admissions to the home were people living with dementia. The training records showed no staff had received dementia awareness training. The deputy manager told us, "We hope to have all staff trained in this by March." This meant that we were not able to confirm that staff had the appropriate skills and knowledge to ensure people's needs were met.

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

Care for people living with dementia required further development. Staff had not received in-depth training in dementia awareness. People living with dementia were not appropriately engaged or stimulated. For example, we saw one person wandered throughout the day and liked to pick up papers that were around the home. We saw there was nothing in place to positively engage the person, such as rummage boxes. The home was not adapted for the needs of people living with dementia. There were no names or photographs on doors and no dementia friendly signage to aid with people's orientation. For instance, bathrooms had small signs and no pictures to help people living with dementia. We saw over the lunchtime that plate guards and adaptive cutlery, crockery or drinking cups were not used to promote people's independence. The plates people ate from were white and the tablecloths were pale cream. This would create difficulties for some people in identifying where their plate was. We saw one person constantly missed the plate with his spoon and was trying to spoon the tablecloth.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS authorisations had either been approved or in the process of being approved by the local authority. People had specific DoLS care plans which gave guidance to staff about how to support people with decision making. We observed staff always asked people for permission before providing care.

Staff understood the importance of seeking people's consent before providing care and support. One person commented, "They [staff] ask you what you want." Staff said they would always ask first and would respect the person's decision. They went on to tell us that if they thought the person needed their help they would try again later to check they were sure. One staff member commented, "We never take it for granted."

People had enough to eat and drink and gave us positive feedback about the meals provided at the home. One person said, "The food is good." Another person told us, "The food is OK." Another person commented, "The food is good but I'm not a big eater." A fourth person told us, "The food is excellent and generally I eat it all."

We observed the lunch time meal to help us understand people's experience. We found people did not always receive help in a timely manner. We saw the dining room had been prepared prior to people arriving with each table set with tablecloths, cutlery, condiments and table decorations. There were 12 people in the dining room, seated in friendship groups. The other people stayed in the lounge, conservatory and in their rooms. The lunch time lacked structure and organisation. As the home was located over four floors we asked one staff member how the meals were organised. The staff member said, "We serve depending on what people have ordered, sometimes it's the rooms, sometimes it's the dining room. If they are hungry they get fed first. We have one [staff member] serving in the kitchen and one [staff member] on the floor."

People were offered a choice from ready plated meals which had been brought to the dining room uncovered on a tray. Staff did not always have the time to attend to people's needs and offer support when needed. For example, we saw two people having difficulty eating their lunch in the dining room but no assistance was offered. Another person had intermittent support from staff when they were in the dining room. The person took a long time to eat their meal and was eventually the only person left in the dining room. The person was not offered dessert or a drink. We observed that the dining room was being set up for a training session whilst the person was still attempting to eat their meal. Staff did respond to some people needs when they were present in the dining room. For instance, one person started using a fork to drink their tea. A staff member noticed this and changed the fork for a spoon. People were regularly left unsupervised during the lunch time as staff tried to respond to the needs of people who were dispersed in the dining room, the lounge, the conservatory and their rooms, as well as staff having to respond to nurse calls which were constantly being activated throughout lunch. For example, after serving the main course in the dining room the staff left leaving people unsupervised. We also observed people unsupervised in the conservatory with meals.

Care records we viewed confirmed people had input from a range of external health professionals when required. We saw there were regular visits from GPs, community nurses and other health professionals

depending on people's needs.

Requires Improvement

Is the service caring?

Our findings

People gave us positive feedback about the care they received at the home. One person said, "I like it here they [staff] look after me." Another person said, "I like it here, [my relative] came and looked at it and thought it best. I like it the girls are nice. I am going out later, I go to Church on Thursdays." Another person commented, "It's canny [nice] here."

People and family members told us staff members were kind and considerate. One person told us, "The girls are nice enough." Another person said, "It's very nice they look after me. They are kind, I have nothing to worry about." Family members stressed to us that despite recent difficulties the staff were kind, caring and committed to caring for people to the best of their ability.

People told us staff tried to meet their preferences. One person commented, "This is a very nice establishment, they look after you and if you ask for something they try and accommodate you and if they can't they come and tell you why. We are fortunate to be here and we are very settled."
Another person said, "It's very good, I have no complaints, if you want something done they do it." However, due to the limited availability of staff we saw people had to wait for assistance when they requested it.

We observed throughout our inspection staff had very limited time to spend with people on a one to one basis. For example, we saw during the morning staff had little time to interact with people. This was because they were constantly answering nurse call bells. Later in the afternoon we observed four members of staff sitting in the conservatory. However staff took this time as an opportunity to catch up on paperwork, which they hadn't had time to complete earlier. Although there were a lot of people in the conservatory staff did not attempt to interact with them. This had a negative impact on people's wellbeing. For example, on one occasion we saw that a person sitting in the conservatory was unwell. There were no staff present to offer reassurance to both the person and other people in the conservatory, who were openly talking about their concern for the person. We had to alert staff to come and offer assistance to the person.

Staff members confirmed they did not have enough time to give people the one to one time they needed. One staff member said, "We can't do anything with them [people] because we are constantly busy. They just get bored. We try and sit down and talk to them but when buzzers are going off constantly you can't do that."

When staff did have time to interact, this was done positively but was brief in nature. For instance we observed a staff member sitting and talking to a person in their room later in the afternoon. We also observed some appropriate hugs and affectionate behaviour towards people.

Inadequate

Is the service responsive?

Our findings

People and family members were not involved in determining their care needs with staff. People using the service had their needs assessed both before and after admission to the home. An assessment had been completed for all 14 people who had moved into the service in January 2016. The assessment template used was a new format the home was implementing with support from the local authority. The assessment covered a range of areas, such as personal care, physical health and medicines. Staff also had access to referral information which provided background information for each person, including their preferences. From discussions with the registered manager we established the assessments for the 14 new people had been completed without their involvement or the involvement of people close to them.

At the time of our inspection the registered provider was in the process of developing care plans for the 14 recently admitted people. The registered manager told us, "The new people have some old style care plans but not for all needs." The format used for care plans was also being changed. However, the registered manager did not have a structured approach to the implementation. The registered manager was currently updating a person's care plans who had not recently moved into the service rather than prioritising new people, some of whom did not have a full range of care plans. The registered manager also told us the information had been given by staff rather than involving the person or a family member in developing the care plans.

We found people's care plans had not been kept up to date to ensure they reflected people's current needs. We viewed the care plans for three people and found care plan evaluations were overdue for all three people. Most care plans had not been evaluated since November 2015.

People did not currently have the opportunity to take part in planned activities. In the hall was a large activities display but it was all for last year. We observed there were no activities organised throughout our inspection. The activities organiser was absent from the home. Family members told us the staff member who was filling in had left. One person told us, "There is nothing to do, the girl is off but we don't do anything, I just sit here." Another person commented there was "not much to do, well I can't do much now." One family member said, "I know the activities organiser is off but when she was off before the other girls would do the activities but now you never see them sitting and talking to the residents. I can't remember the last game of bingo or anything." One staff member told us, "There are some that [activities organiser] had already booked, so they will still come, singers and stuff."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views from family members about the care provided in the home. Some family member felt their concerns were not being dealt with effectively. They told us they had raised issues recently with the owner and registered manager but had not received any response to them. However, there had been no formal complaints made about the home. Details of how to make a complaint were displayed prominently on the notice board.

Inadequate

Is the service well-led?

Our findings

Communication between the home, people and family members needed further development. People and family members told us they had received surveys in the past but not for a while. We asked the registered manager about consultation and she confirmed this was overdue. The last consultation had been carried out in 2013. Family members told us there had been no 'residents' meetings' recently.

Audits of medicines records were ineffective in improving the quality of medicines records to ensure people received their medicines safely and in a timely manner. During our inspection we found a small number of gaps in signatures on three people's MARs. We found no evidence these had been identified and investigated during medicines checks. The frequency of some medicines checked had been reduced recently from weekly to fortnightly. One staff member told us, "I usually do the medicine count every week, but with the extra people in the home I am now doing it every two weeks. We are still getting sorted with the medication of the new people." We found no evidence the registered manager had any oversight on the quality of medicines records. Staff told us the registered manager carried out checks on the competency of the staff who administered medicines. However, we found no records to confirm these checks had been carried out.

We found that due to a lack of leadership and management oversight within the home important procedures to keep people safe had not been followed. For example, some recruitment checks had not been carried out, staff supervision and appraisal was overdue and training had not been completed. The registered manager had also not monitored the impact of staffing levels on people and staff following the recent admission of 14 people into the home in January 2016.

We found quality assurance checks to ensure the safety and wellbeing of service users were overdue. For example, we viewed the 'monthly infection control monitoring' for the home. We found this was last done in December 2015. There was also no record of any infection control monitoring for November 2015. Other checks were also overdue and had not been completed since November 2015, such as reviews of staffing levels and monitoring people's weights.

The 'weekly falls matrix' showed there had been an increase in falls in the home since January 2016. Although action had been taken to keep people safe following each accident there was no evidence that falls had been analysed to identify any areas for improvement or lessons learned. We viewed the monthly accident analysis and found this had not been completed for January 2016. We also saw that prior to January 2016 the analysis had not been fully completed. The template used to record the analysis prompted staff to record the 'causes' of accidents and incidents and to assess the 'level' and 'severity' of the accident. We found this had consistently been left blank. We viewed the 'monthly accident analysis audit' and found this had also not been completed in December 2015 and January 2016.

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

The home had a registered manager. Staff gave us positive feedback about the registered manager. One staff member said, "Sue [registered manager] knows what she is doing and she is a good manager." There was a welcoming atmosphere in the home. We observed family members were welcomed into the home and were greeted by name when they arrived. They said they were free to visit at any time.

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 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not planned jointly with the person and care plans did reflect people's preferences about how they wanted to be supported. Regulation 9 (2) (a) and 9 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not followed effective recruitment procedures when recruiting new staff. 19 (2) (a) and 19 (2) (b).

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 The registered provider did not have effective systems to assess, monitor and improve the quality and safety of the service provided to service users and to mitigate the risks relating to the health, welfare and safety of service users. Regulation 17 (2) (a) and 17 (2) (b).

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably staff deployed staff to meet people's needs and keep them safe. Staff had not received regular supervision, appraisal and training. 18 (1) and 18 (2) (a).

The enforcement action we took:

We issued a warning notice.