Warren Heath Residential Home Limited

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Inspection report

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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

Overall summary

The inspection took place on 31 January 2015, the inspection was unannounced.

The service is a residential home for 17 older people, some of whom may have dementia. The service is privately owned and both of the providers are active in the service, one of the providers is the 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.

Summary of findings

People told us that they are happy and feel safe in the home, but we found some examples in the way the home was working that meant that they may not be well cared for or safe all of the time.

Some people had not had their needs assessed before they moved in to the home and did not have a care plan, others care plans had not been fully updated and did not show present needs.

Risk assessments around making sure people did not develop bed sores and remained healthy were in place and were reviewed regularly, but we found that other risks around moving and handling people had not been assessed.

People's day to day health care was looked after and the doctor, or other medical advice, was sought when it was needed.

The provider did not make sure people were warm enough. We noted and people told us that they were cold at times. Some people told us that their families had brought in extra bedding so they were warm at night. We also noted that the corridor lights were kept off with the expectation that people could turn the lights on if they wanted to move about independently, but this put them at risk of falling over objects they could not see.

The staffing levels are not always sufficient to keep people safe. There are times on the rota that showed only one staff on duty. We also saw that the rota did not reflect the actual number of staff on duty.

We saw that medicines were not managed well and that best practice was not followed in giving people their medicine.

People told us that they felt well cared for and during our inspection staff interacted well with people and listened to what they had to say. The staff are friendly and helpful to people. The staff and the registered manager know what action to take if they think anyone living in the home is being harmed in any way.

People's privacy and dignity is not always protected by the service. People's care plans and other written information are not kept in a safe place to stop others seeing it.

Staff receive an induction when they start working at the home and are trained and supported in their work by the registered manager, although their competency in some areas is not always effectively assessed and they are not given the opportunity to attend staff meetings to discuss and plan people's support needs.

People told us that they get enough to eat, are given a choice and that the food is well cooked, but they always eat their meals in their armchair. They are not given the choice to eat at the table with others to enjoy some social interaction. Some people told us that the days are long and boring and that sometimes they only leave their chair to go to the toilet and bed. There are some activities on offer. A staff member is employed to offer people company, read to them and to play board games with them, and entertainers are brought into the home regularly.

The provider does not effectively consult people on their views about the quality of service they receive, and the registered manager does not properly assess, monitor and improve the quality and safety of the service provided.

People told us that the staff would listen to their complaints, and relatives we spoke with said they were confident their complaints would be dealt with. However, the complaints people told us about are not recorded. The registered manager makes themselves available to people who want to talk to them and is involved in the day to day running of the home. Some improvement is needed in the way they audit the quality of the service, staff performance and the way that records are updated and stored.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and welfare were not always assessed or managed appropriately.

People were not protected from the risks of being cold. The home was cold in some areas.

Lights in dark corridors were kept off, which put people at risk of falling.

There were not always enough staff on duty to ensure people's safety and the medicines were not always managed or administered safely.

Is the service effective?

Requires improvement

The service was not always effective in meeting people's needs.

Staff training was not always effective. Staff were seen not following best practice while giving people their medicines even though they had been trained.

Staff understood the relevant requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) and knew what action to take if they thought people had been harmed in any way.

People had enough to eat and drink, but their mealtime experience was poor as they were not given the opportunity to mix or socialise during mealtimes.

People received effective healthcare support.

Is the service caring?

Requires improvement

People's dignity and privacy was not always respected. Personal information was sometimes left in an area open to others.

During our inspection staff interacted well with people and listened to what they had to say. The staff were friendly and helpful to people.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

There was no evidence that preadmission assessments had been carried out and one person did not have a care plan in place, so staff would not know how to meet their needs.

Nor had care plans been updated to reflect people's current needs and risk assessments had not been always been completed.

Summary of findings

People were not always asked for their personal preferences and they did not get many opportunities to follow their interests or to take part in meaningful activities.

The providers did not effectively consult people on their views about how the service was run. The provider responded to complaints but did not record what action they had taken or the outcome of the complaint.

Is the service well-led?

Inadequate

The providers were in the home on a daily basis supporting people with their personal care needs, but the storage of records was not well organised and they had problems finding some of the records we asked to see.

Monitoring systems were not robust and failed to identify shortcomings we found during our inspection in the management of medicines and care planning.

The provider did not always make the safety of the people who lived in the home their top priority.

Warren Heath Residential Home Limited

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 31 January 2015 was unannounced. The inspection team consisted of two inspectors.

During our inspection we observed how the staff interacted with people who used the service, including during their lunch. We used our Short Observational Framework for Inspection (SOFI) tool. The SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

In advance of our inspection we looked at information we hold about the service. This includes any notifications received about or from the home, A notification is information about important events which the provider is required to send us by law. We also reviewed local authority quality monitoring reports.

We spoke with eight people who used the service and six of their relatives and other visitors. We also spoke with both of the providers, one of which was also the registered manager. We spoke with both of the two care staff that were on duty and the cook. We also reviewed four people's care records, four staff personnel and training records, and records relating to the management of the service such as audits and policies.

Inadequate

Is the service safe?

Our findings

Risks to people's health and welfare were not always assessed and managed appropriately. For example, we found that one person did not have an assessment of need or a care plan in place. Another person's moving and handling risk assessment had not been updated for four years, their care plan stated that they moved around using their walking frame, but we saw they were being cared for in bed and were no longer able to stand unaided. They needed to be hoisted in and out of bed. This meant that the person had not been assessed to decide which hoist best suited their needs or which sling to use. The use of the wrong sling could result in accidents and injuries, people could fall out of a sling that is too big for them.

We found that the registered person had not protected people against the risk of receiving care that was inappropriate or unsafe. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that other assessments were in place, for example we saw risk assessments that evaluated the risks to people developing pressure ulcers and malnutrition. Pressure ulcers are a type of injury that breaks down the skin resulting in an open wound. They are caused when an area of skin is placed under pressure. Managing pressure areas effectively reduces the risk of people developing pressure ulcers, which are painful and could lead to other health complications.

People were not protected from the risk associated with being cold. The home was cold and people told us that their families had to bring in extra blankets or thicker quilts so that they would be warm at night. One person said, "I sit in my room all day and it gets chilly, at night I have an extra blanket over me and my dressing gown so that I am warmer." A person's family member told us, "The heating is turned off in the bedrooms during the day, my [relative] is frail and stays in bed. I brought warmer bedding in for them. I mentioned it to the manager, who said the heating will be left on, but the room is always cold. I came in today and had to adjust the radiator."

There were several people who preferred not to go to the main lounge once they got up and some were nursed in bed. During our inspection we noticed that corridors upstairs and downstairs and the bedrooms were cold, in some bedrooms the windows were open for fresh air as well as the radiators being turned off. The registered manager told us that they asked the staff to turn the heaters off during the day as a fuel economy measure. When asked they said that they did not monitor the temperature in the home and did not know the recommended safe temperature range a care home should be kept within. People's health and wellbeing was put at risk, some older people are not able to control their body temperature, therefore the home should be kept at a temperature that would enable people to feel warm and comfortable.

We also noted that the lights on the corridors upstairs were off, as were some of them on the downstairs corridors, again as an economy measure. However, it is not a safe practice because it adds to the risk of people tripping as they may not see hazards in poor lighting.

We found that the registered person had not protected people against the risk of being cold. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safe in this home because the staffing levels were not always sufficient to keep people safe. We had been contacted before our inspection by people who were concerned about the staffing levels at Warren Heath Residential Home. We were told that the staff listed on the rota for duty did not always correspond to the people that were actually working the shift, especially at weekends. During our inspection we found that this was the case. For example, when we checked the staff on duty against the rota we saw that there was a discrepancy. The rota indicated that the registered manager/provider and the other provider would be on duty as well as four other staff. However, although the rota stated that six staff would be on duty that day, only two care staff and the cook were actually in the house.

At the time of our inspection there were 15 people living in the home, when we arrived there were three staff on duty, two were care staff and the third person told us that they

were the cook and did not participate in caring for the people who lived in the home. However, they later informed us that they were responsible for giving people their medicine.

One staff member arrived within half an hour of our arrival. They said they had been collecting some shopping on the way in to work, although the rota stated that their shift started two and a half hours earlier. Staff on duty had already confirmed that they were not expecting any further staff to work at the service that day.

Both the registered manager and other provider arrived at the home at 2.10pm. They had been on the rota that day to start shift at 7am. Staff with whom we had spoken had confirmed that they were not expecting the manager or provider to be working on shift that day.

When we spoke to people some thought there were not always enough staff on duty, which meant they had to wait long periods before they got the assistance they needed.

The rota showed that there were periods of the day when there was only one staff member on duty, which left people at risk because the staff member would have to look after the people in the main lounge as well as the people who chose to stay in their bedroom or those who were being nursed in bed. There could be long periods when people would not be supervised and may have to wait a long time for assistance. The rotas indicated that five staff were on duty every day between 7am and 8pm, with three of the staff taking lunch between 1pm and 2pm. However, on the day of our inspection the rota indicated that only one staff member was to be on duty between 1pm and 2pm along with both of the providers. However, they did not arrive at the home until 2.10pm.

Comments people made indicated there were not always enough staff on during the afternoon. One person told us, "I need the hoist to transfer me from the bed to the chair during the afternoon, but they often only have one member of staff using the hoist and I know that's not right." Another person said, "Yesterday I called for help to go to the toilet at 6.45pm, I had to wait until the night staff came in at 8pm before anyone would help me to use the bed pan."

The registered manager told us that they did not have a system in place to regularly assess people's care needs, which they would use when calculating staffing levels.

We found that the registered person had not ensured that there were sufficient staff on duty to meet people's needs. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were not safely managed, which put people are risk of not getting their medicine at the right time or in a safe manner. The medicine records we checked showed that medicines were not checked in when they were delivered from the dispensing pharmacy. The service did not have records of what medicines had been received, meaning that they would not be able to effectively audit the medicines to check that they had been given properly or if any had gone missing.

When checking stock against what was recorded as having been given to people, we found that two people's records showed medicine that had been signed for as given but was still in the box. Medicines were not always stored safely; one person's eye drops had instructions printed on the container that they should be stored in a fridge once they were opened. They were not stored in the fridge but kept in the medicine cabinet.

Medicines were not effectively audited, which meant that mistakes were not identified and that appropriate action was not taken to rectify them. When asked, it took the registered manager some time before they could find where the medicine audits were kept. When they were located, only one was available for us to look at. The audit was not clear and did not state who and what medicines were checked and did not identify the errors we found during our inspection.

The cook told us that whoever was doing the cooking was responsible for giving people their medicine. They said that they did not support people with their personal care and did not have access to their care plans. It is not good practice for a staff member to give people their medicine when they are not actively supporting people and are not aware of their health needs or medical history. They would be unable to recognise changes to people's health and would not be aware of any special needs around people taking their medicine or changes to medicines.

Staff had not been adequately assessed as being competent to give medicines. Although the training records

Inadequate

Is the service safe?

showed that all staff had received medicine training, only one person had been assessed as competent. The registered manager told us that they had only recently implemented these assessments.

It was the cook on duty who had been assessed as competent. We observed them giving people their medicine. We noted that they did not sign each individual medicine record as the medicine was given, but waited until they had cleaned the kitchen after dinner before they signed all the records. This contravenes all accepted guidance for the safe administration of medicines and is an unsafe practice as the records may be wrongly completed, which could put people at risk of medicine mistakes.

We found that the registered person had failed to ensure the proper and safe management of medicines. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

One person who lived in the home told us, “I can speak up for myself and I would know who to speak to if I needed to.” The registered manager knew what action to take if they suspected that anyone had been abused. Our records show that the service sent us statutory notifications when incidents of note occurred and informed the local authority appropriately if incidents of abuse were suspected.

Staff told us, and records confirmed, they had received training in protecting adults from abuse and how to raise concerns. Staff were able to demonstrate the action they would take and who to report concerns to in order to protect people.

Requires improvement

Is the service effective?

Our findings

Staff said they received regular supervision. Although, the supervision records we saw indicated that the records were very similar, possibly cut and pasted from one to another with only minor amendments made to each. They did not differ in content and did not relate to the individual staff member. This meant that staff may not have had meaningful supervision meetings that were tailored to their individual needs, capabilities and competences. It was not evident that staff had received appropriate support to carry out the duties they were employed to perform.

The training records on staff files and those the registered manager sent to us after our inspection showed that staff had sufficient training to enable them to carry out their roles and responsibilities. However, the medicine training was not effective in preventing the errors that we noted during our observations and during our check of the medicine records. Staff competence had not been checked in this area, although the manager told us that this had recently been put in place and we saw the first one that had been carried out. However, the one person who had been assessed as competent was seen not to follow safe practice, which would suggest the assessment was not effective.

Staff induction records were present on the staff files we looked at, which meant that staff had been able to familiarise themselves with the building and the provider's policies and procedures when they started working there.

People had sufficient to eat and drink. The cook told us that people were consulted on their choice of food and were given two options at mealtimes. The food portions appeared small, but when asked people said they had enough to eat and that they enjoyed their food. One person said, “There is more than enough food. If I want anything else they get it for me.” another person said, “We are offered a choice of food.”

People’s overall meal experience was not a stimulating one. People were not given an opportunity to move from their armchair and sit at the dining table. Everyone remained in their chair and ate off individual tables. This meant that they did not have the opportunity to socialise with others, different to those they spent most of the day sitting next to.

There were not enough chairs or tables for everyone to sit at a table to eat. We saw seven chairs and three small tables against the wall in the dining area of the lounge. The room would have been very cramped if the table and chairs had been arranged in a position for people to sit at them. It was evident that the dining tables were not used at mealtimes because they were covered with the established clutter of records, care plans and other documents. If anyone wanted to sit at the table It would have been difficult for them to have found a clear space to eat.

During our inspection we saw that people spent most of their day in their easy chair and only moved when they wanted to go to the toilet. They had not been asked their preference or assessed to establish whether they would benefit from sitting at the dining table to eat. People benefit intellectually from the social interaction and are stimulated by a change of view, the exercise and chatting amongst friends. Good practice would ensure that mealtimes would be a social event. One person told us, “It can get very tedious, we never move and do very little all day.”

Staff had attended Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) training. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The registered manager had an understanding of both the MCA and DoLs and when these should be applied to the people who lived in the home, including how to consider their capacity to make decisions. No one was currently living at the home that was subject to a DoLs. The registered manager told us that in the past there had been one person who had been identified as needing a DoLs and they had taken the necessary action. We saw that people’s capacity had been assessed and records of the assessment were seen in their care plans.

People’s care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs. The home had regular contact with a GP's surgery that provided support and assisted staff in the delivery of people’s healthcare. People were supported to attend hospital for follow up appointments.

Requires improvement

Is the service caring?

Our findings

On the whole people told us that they felt well cared for and that staff were attentive to their needs. One person said, “The staff here are helpful.” Another person said, “They [the staff] are good people, they work very hard but are rushed at times.” Someone’s relative told us, “I am very happy with the care here.”

There were good interactions between staff and the people who lived in the home throughout our inspection. Staff were friendly and helpful, it was obvious that they knew people well and had built up a good relationship with them. There was a relaxed atmosphere and easy banter between the two groups. When staff talked with people, we saw them sitting next to them and giving them time to answer.

A visiting hairdresser told us that they had seen staff working well with people and that their knowledge of their likes and dislikes had made their job easier. People told us that staff consulted them on how they wanted to be supported and gave people choices where they could. One person said, “I get to choose when I have my bath and when I go to bed,”

However, we noted that the staff signing in book was also used as a logbook, where staff shared messages about people’s care needs and appointments, it also contained messages from the manager to staff. The signing in book was kept in an unlocked room that everyone had access to. This did not promote people’s privacy because private information could have been accessed by other people who lived in the home as well as visitors. People’s care records were kept in the main lounge on the dining table, which left them vulnerable to being read by people other than those they involved. The safe storage of personal data must be considered to ensure people’s privacy is respected.

Inadequate

Is the service responsive?

Our findings

People did not always have care plans in place that identified their needs or how they would be met. There were no preadmission assessments present in people's care records. One person did not have a preadmission assessment or care plan in place, which meant that staff were caring for that person without any knowledge of that person's support or health needs, preferences or ability to do things for themselves.

The care plans did not always reflect people's current needs. Three of the care plans we looked at had been written a long time, one person's was written four years ago, but they had not been updated clearly, other than hand written notes of information on the existing documents, making them confusing to read.

Care plans did not always record people's individual interests and people's preferences were not asked. For example one person told us, "They wake you up between 7 and 8 am. You have to get up otherwise you miss breakfast. I go to bed when I want."

People told us that they did not get many opportunities to follow their interests or to take part in meaningful activities. One person said, "It can get very boring, I sit in the same chair all day and only get up to go to the toilet or go to bed." The home did employ a staff member who spent time with people reading to them, playing table top games and generally helping them if they asked for help reading their mail etc. However, at the time of our inspection this staff member was only 16 years old and was restricted in the time they spent at work and the support they gave people. They were not able to give personal care or to take any responsibility within the home other than undertaking activities while under supervision.

The manager told us that they did have entertainers in the home and took people to the local shops individually. One relative told us, "I come and play guitar on a voluntary basis, everyone loves it." But all of the people we spoke with agreed that there were not enough activities arranged to keep them occupied and their minds busy. One person who chose to stay in their bedroom told us, "To be truthful, other than when they bring me my food, I don't see much of the staff. I ring if I need anything and they come fairly quickly." Another person said, "I read my paper, have my hair done and play dominos or bingo. It would be nice to go out more." A relative told us that their family member, who is cared for in bed, got very little one to one time with staff apart from when they were receiving personal care.

We found that the registered provider had failed to support people to take part in meaningful activities of their choice. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care notes were not regularly being recorded, some people's daily records had two day gaps in them, meaning that a contemporaneous record of care and treatment was not being kept, which could lead to important changes to people's care needs and health being missed by staff leading to mistakes that could put people at risk.

We found that the registered person failed to ensure that accurate, complete and contemporaneous records in respect of each person were being kept. This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers did consult people on their views about how the service was run, but it was not always done in an effective way. The registered manager held joint 'staff and resident' meetings. Joint meetings would prevent people from having the opportunity to share any concerns they had about staff who cared for them, nor would staff be able to talk openly about the concerns they had about the people they supported. The aim of having meetings where people and staff could openly air their views and concerns about the service was not met by joint meetings.

There was one set of meeting notes available for us to see for a meeting held in January 2015. There were only two topics covered; apologies for the recent building work, and people were informed that they were going to be offered questionnaires to complete to provide their views about the quality of service. The small range of topics illustrates the difficulty of holding joint meetings.

People told us, "They send you a survey once a year." And, "I am not aware of any residents meetings but we do have some paper with questions on asking us our views." We saw that the service carried out an annual survey to ask the people who lived in the home and their families for their

Inadequate

Is the service responsive?

view of the service offered them. The response to the last survey completed in October 2014 was low, six people responded but all the comments were positive. The registered manager told us they had not considered taking steps to increase the response to the next survey they sent out.

We found that the registered person failed to seek and act on feedback from people for the purpose of continually evaluating and improving the service. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system in place for recording complaints. There were four complaints recorded, all of them had been concerns raised by the local authority and had been investigated by them.

None of the people we spoke with were aware of any complaints procedure, but all of them told us that they would be happy to go straight to manager and the other provider. Relatives said that when they had complained matters had been dealt with promptly. One relative told us, "We have only had to formally complain once ….We complained to [the registered manager] and it was resolved."

Although we had been told that people had made complaints, none of them were recorded. This meant that the providers did not operate an effective system for identifying, receiving, recording, handling and responding to complaints, which meant that we could not be confident that they were managing complaints properly or in line with their complaints procedure.

We found that the registered person failed to establish an effective system to deal with and record people's complaints. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The providers did not maintain robust records or have a robust data management system in place. The staff records we looked at were well ordered and contained all the information we needed to see to ensure that staff had been recruited properly. But some of the records were not as well organised. When we asked to see sample records, the registered manager took some time to produce them and, on more than one occasion, they could only find one copy of the record we asked for. For example, they could only find one 'staff and user' meeting notes and one medicine audit for us to examine. This meant that we could not judge consistency within the audit system.

We found that the registered person failed to effectively keep and maintain records in respect of people, staff and audits carried out within the service. This a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite people and their families complaining that the some parts of the building were cold, the provider did not monitor the temperature within the home, there were no thermometers in the communal areas and none in people's bedrooms. Nor were they aware of the optimal temperature range a care home should be kept within to safeguard the people who lived there. When asked what that range was, the registered manager answered, "I don't know…. 36?" They told us that the radiators in the bedrooms were turned off during the day to save on energy costs, the lights in the hallways were turned off for the same reason, commenting that people could turn them on if they needed them. We discussed the dangers of people being at risk if they were unable to regulate their body temperature due to ill health or age and the risk of people falling in unlit corridors where they may not see trip hazards. The registered manager assured us that they would ensure that the home was kept warm in all areas and that the lights in all communal areas would be left on in future.

The registered manager told us that they and the other provider were in the home on a daily basis when they monitored the quality of care, but they did not have a formal, on going quality assurance system in place. We found that the audits that were carried out were not always effective. For example the audit of medicines did not state whose or which medicines were checked. The audit we saw did not identify the errors we found during our inspection, which means that it was not fit for the purpose of checking that the medicines were stored, recorded and dispensed properly. The care plans were not routinely monitored by the registered manager. We found examples where they did not truly reflect the needs of the people who lived in the home. One person did not have a care plan in place. This meant that we could not be confident that their changing needs would be assessed and met.

We found that the registered person failed to monitor the quality and safety of the services they provided. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they were confident that the registered manager would deal with any issues they brought to their attention. Staff also told us that they received regular supervision, although those records we reviewed were very similar from one supervision to another, with sometimes only minor amendments made to each. The registered manager maintained a visible presence in the home; supporting people with their care needs while also reviewing what happened on a daily basis and monitoring staff performance.

People who lived in the home and visitors to the service told us that the registered manager made themselves available if they wanted to talk to them and felt that they would deal with any issues raised. One person told us, "If I was unhappy about anything I would go to [the providers]." A relative said, "Whenever I have brought anything up, it's dealt with."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Which corresponds to Regulation 9 (1)(a)(b)(c) (3)(a)(b)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has failed to develop care plans that are appropriate, reflecting people's needs or to reflect their preferences. Nor were the risks to people properly identified or plans to minimise risks to people put in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Which corresponds to Regulation 12 (1) (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that the service was kept within a safe temperature range or that the lighting was adequate to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Which corresponds to Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The service has failed to regularly assess and monitor the quality of the service provided and have not taken action to identify and manage risks relating to the health, welfare and safety of the people who use the service.

Nor have has the provider taken effective steps to regularly seek the views of the people who use the service, their representatives and staff to enable the provider to come to an informed view in relation to the standard of care and treatment provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that there were sufficient staff on duty to ensure that people were safe and their care needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Which corresponds to Regulation 16 of the Social Care Act 2008 (Regulated Activities) Regulations 2014. The providers did not operate an effective system for identifying, receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Action we have told the provider to take

Which corresponds to Regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care notes were not regularly being recorded.