Encompass (Dorset)

Dick O'th Banks Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the time of the inspection there was a manager in post who was registering to become 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.

At the last inspection in March 2016, the service was rated Good. At this inspection we found the service Required Improvement.

We were unable to speak to people to ascertain their views as to the approach of staff in caring for them due to their limited verbal communication skills. We spent time observing interactions between staff and found staff to be friendly and kind in their approach towards people.

People were supported by staff they knew well and trusted. However they did not have maximum choice and control of their lives and therefore were not supported in the least restrictive way possible. People did not always receive care that was responsive to their needs and improvements were required to the home's approach to person centred care.

People were living with a learning disability, autism or had needs relating to their mental health, which affected their ability to make some decisions about their care and support. Staff showed a good understanding of the Mental Capacity Act 2005 (MCA) and their role in supporting people's rights to make their own decisions. However they required more training and support to meet people's communication needs.

Care plans were personalised and evidenced how people would like to receive their care, however information held within the care plans was out of date. At the time of the inspection reviews were taking place, which meant care plans would be updated and transferred to the providers on line monitoring system.

Staff understood their responsibilities with regard to reporting suspected abuse in order to safeguard people from harm. Guidelines were followed by staff to minimise the risk of harm to people and minimise re occurrences of any incidents. However there were not enough staff to minimise risk.

There were not enough staff to support people that presented a risk to themselves and others. There were not enough staff to provide meaningful activities for people and to be supported to pursue individual interests. Recruitment checks were completed to assess the suitability of the staff employed.

People had their medicines ordered, stored, administered and recorded safely. All staff received medicine administration training and had to be assessed as competent before they were allowed to administer

people's medicines. People were supported by staff to attend medical appointments.

Staff told us the majority of the cleaning duties took place each night. However cleaning records showed this was not done consistently. Staff had completed infection control training. When things went wrong lessons were learnt and actions put in place to improve safety.

Systems and processes were in place that monitored the quality of the service. However these audits were not fully effective at identifying the shortfalls in the service we found during our inspection. Systems and processes had not identified people were at risk of social isolation or having appropriate support to meet their communication needs or information in records were out of date.

Arrangements for oversight of the service required improvement to identify and respond to concerns and risks. The new manager was also under a new management structure. There were planned changes to the registration of the service and staff told us they were aware of changes to the service and were awaiting training on how to deliver support under the new registration of supported living.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read at the back of the full report what action we have told the provider to take.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

There were not enough staff to provide meaningful activities for people and to manage risks.

Medicines were stored safely and effectively monitored. Staff had received medicines training and their competency was assessed.

Areas of the home had been adapted to ensure equipment was safely maintained and suitable for people to use. Infection control protocols were followed by staff

There were arrangements in place to check staff employment history and suitability before they started work

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by people who had the appropriate training to deliver good standards of care.

People received good nutrition and hydration and people were involved in meal planning to ensure their preferences were met.

Staff supported people to visit health care professionals to ensure their medical needs were met.

The premises were suitable for people who lived in the home.

People's consent was sought in accordance with the Mental Capacity Act 2005

Is the service caring?

Good

The service was caring.

People received caring support and were supported by staff who knew them well

People had their dignity, privacy and independence respected

Relatives were welcomed in the home and involved in making decisions about people's care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to support staff to communicate with people in accessible ways that took into account any sensory impairment

People's care plans held out of date information about people's individual needs.

The provider had arrangements in place to respond to complaints and a complaints procedure

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements were required to how the service was monitored and systems reviewed.

The provider had been proactive at identifying additional resources to support the improvements required and this was on-going

Dick O'th Banks Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 April 2018 and was unannounced. The inspection continued on 27 April 2018 and was announced. The inspection was undertaken by one inspector.

Prior to the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

People using the service were unable to speak with us, therefore we observed interactions between staff and people using the service. We spoke with the manager, operations manager, team leader, and six members of care staff. We also spoke with one relative, three health professionals, and gained information by email from a further two health professionals.

We looked at care documentation relating to two people, one person's medicines administration records, four staff personnel files, staff training records and records relating to the management of the service including quality audits.

Requires Improvement

Is the service safe?

Our findings

People were not able to tell us about their experience of living at Dick O'Th Banks Road, but appeared at ease with the staff who were supporting them. At the time of the inspection all health and social care professionals and relatives we spoke to told us that they had no safeguarding concerns. Relatives told us they felt their loved ones were safe. However there was a risk that people may not be cared for safely as staffing levels were insufficient to support people safely in the community.

There was not enough staff to meet people's needs. For example, one person was assessed as requiring two staff support while away from the home. Staffing had not always been arranged to support this person in the community. Another person was assessed as requiring one to one staffing while out, however support for this person was not always arranged to meet their needs. Their personal profile stated 'individual attention made them feel important and wanted'. The team leader confirmed people had been unable to have their identified needs met due to insufficient staff to support individual activities and interests within the community since individual staffing support for one person had ended in July 2017.

One relative told us, "When [name] had a personal assistant it was lovely as they could come home and spend the day with us. They miss that, I would like to see [name] more often at home." They told us the person had not been home to see them since the summer of 2017. They told us "It was also important for [name] to been shown pictures so they could choose where they wanted to go. They told us "They used to choose to come home." The provider told us they had actively been trying to recruit with limited success.

There were a number of staff vacancies which were covered with agency staff. Staff told us there had been a higher than normal staff turnover in the last year, and the home had relied on agency staff. A member of staff told us agency staff did not always have, "The confidence to take people out alone or have the skills to drive the vehicles".

There were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Staff had received training in safeguarding adults, and had a clear understanding of what may constitute abuse and how to report it. We reviewed the training records which confirmed this .Staff were aware of how to report to the local authority safeguarding team and whistleblowing procedures were in place. Staff were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe.

Staff recorded and reported any concerns they had, including any changes in a person's behaviour so appropriate action could be taken. Some people presented behaviour which challenged staff and the service. We found that positive behaviour support plans were in place, although these plans had not been reviewed on a regular basis, staff were able to describe how they supported people when they were anxious. However it was important these plans were up to date to support staff who were not familiar to working with

people living at Dick O'Th Banks. The manager told us, "We always ensure there is a regular member of staff on each shift."

Systems were in place to ensure people received their medicines safely. All staff received medicine administration training and had to be assessed as competent before they were allowed to administer people's medicines. Medicines were securely stored and people's Medication Administration Records (MAR) showed when medicines had been administered. No one was receiving covert medicines, although one person chose to have their medicine in a yogurt and we observed staff administering it in this manner. One health professional told us, "I trust the team, they have the confident to allow medicines to work, they don't excessively call but keep me informed of any changes in behaviours I need to be aware of."

The service worked in partnership with local GP's and other health professionals to regularly review and assess medicines in line with Stopping over medication of people with learning disability, autism or both (STOMP). STOMP is an NHS-led campaign and is about making sure people get the right medicine if they need it. It encourages people to have regular medicine reviews, supporting health professionals to involve people in decisions and showing how families and social care providers can be involved. We observed one person who medicines was being reviewed, best interest decisions were being made in regards the person receiving some medical intervention. This meant that medication reviews were taking place to ensure all people were receiving the correct medicines, with the relevant professional guidance.

The home was not always clean. During the first day of the inspection we observed areas of the home looked unkempt, for example windows were dirty, tables had food stains, and TV protectors had finger marks. Staff told us the majority of the cleaning duties took place each night. However cleaning records showed this was not done consistently. One member of staff told us, "It can be difficult to complete the cleaning if people are awake at night." The manager, who was unable to say if the gaps meant the cleaning, had been completed or not. They told us they would discuss the importance of maintaining record at their next staff meeting. Staff had received training and wore Personal Protective Equipment (PPE). Staff had received food hygiene training and correct procedures were followed where food was prepared and stored.

People had their own evacuation plans if there was a fire in the home or if they needed an emergency admission to hospital. Staff had access to an on-call management system which meant they were able to obtain extra support to help manage emergencies. However although weekly fire tests were completed the file folder held the wrong information in regards the amount of people who lived in the home. We shared our findings with the manager. On the second day of the inspection the file had been updated in regards the names of people living at the home, but still contained some out of date information.

To ensure the environment for people was safe, specialist contractors were employed to carry out fire, gas, and electrical safety checks and maintenance. The service had a comprehensive range of health and safety policies and procedures to keep people safe. Management also carried out regular health and safety checks, which included spot checks.

Accidents and incidents which occurred in the home were recorded and analysed. In line with their legal responsibilities the manager had notified the Care Quality Commission which had occurred.

Requires Improvement

Is the service effective?

Our findings

Staff were not supervised in line with the provider's policy and had not received training to support people's communication needs.

Staff had not always received effective training to meet people's needs. The provider was advised by health professionals in 2017 that staff should receive training specific to supporting people with their communication needs such as intensive interaction. Intensive interaction is an approach for teaching communication skills to staff. Records identified and staff told us this training had not been delivered. The manager told us, "I am aware there are gaps in the training programme I have started to get the training up to date. I am also learning to get to know the people living here."

Staff had received training in a variety of topics such as fire, first aid and autism. Staff received an induction before they started supporting people. A national tool was used to ensure that staff learned about the different standards of care and treatment. New staff shadowed more experienced staff members and this was recorded and competence considered before staff worked. Staff told us they had "Lots of training opportunities and "My induction was good." Following their induction staff told us that they had access to on-going training and development. They told us that they were encouraged to undertake national health and social care qualifications.

Staff were not receiving supervision and appraisals as expected by the provider. The provider's policy stated staff were to receive supervision every eight weeks. Staff had not received supervisions in line with the provider's policy. The operations manager told us, not all supervisions were recorded, and may have taken place informally. Staff told us they had not been receiving regular supervisions.

People were living with a learning disability, autism or had needs relating to their mental health, which affected their ability to make some decisions about their care and support. Staff showed a good understanding of the Mental Capacity Act 2005 (MCA) and their role in supporting people's rights to make their own decisions. During the inspection, we observed staff putting their training into practice by offering people choices and respecting their decisions within the home. Staff told us how they supported people to make decisions about their care and support.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care records held best interest decisions including details of people's circle of support who were involved in the decision making process. Circle of support are people's family and friends or anyone important to them.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The

procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although applications for DoLs had been submitted there were issues with them being processed. At the time of the inspection the operations manager was in contact with the local mental capacity team in regards chasing and resubmitting DoLs applications. Following the inspection information was shared that DoLs applications were being processed

People were effectively supported to ensure they had enough to drink and eat. Care staff prepared and cooked meals. We observed the lunch time meal in the dining room. People had one to one support from staff whilst eating their dinner and were encouraged to "take their time" and offered drinks of their choice. When people wished to receive additional food or drinks throughout the day they were observed to guide staff to the kitchen. People were able to access the kitchen area with staff support throughout the day.

People were involved in weekly menu planning meetings and people's individual likes and dislikes were taken into consideration. On the second day of the inspection people were supported to do some cooking. Menu boards showed what main meal would be available for the week. One member of staff informed us that menu boards had been reintroduced in January. Menu boards held pictures of meals people had chosen to eat. They were important as they were visual aids to remind people of what they would eat for their meal. A team leader told us they were unsure why they had stopped being used, but was keen to reinstate more communication aids in people's daily lives.

The home was sparsely decorated with minimal pictures, and was in need of updating. The provider informed us in their PIR "There is building work planned to improve the environment of the home by providing a new kitchen and bathroom, new patio doors and a ramp instead of steps is also being considered. Redecoration of the internal rooms to improve on and make more comfortable living accommodation for service users. A new sensory room is being planned. All these improvements will enhance the quality of life for the service users". This was confirmed by the manager at the inspection. People were able to access all areas of the home either independently or with staff support. They were able to spend time together in a large lounge or garden, or to spend time alone in their rooms or with their visitors.

People were supported to maintain good health and have access to healthcare services. The manager and operation manager told us that they had a good relationship with the local learning disability team's and other professionals. A visiting professional from the learning disability team confirmed they were kept informed of people's wellbeing and the home contacted them with any concerns. Health visits were recorded in people's care files. People had hospital and health communication passports which were shared with professionals during appointments and hospital admissions. These detailed people's, preferences, medicines, communication needs and allergies.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day to day care and support. Relatives told us they felt their loved ones were treated kindly. People knew how to seek support and were observed to be listened to.

Care plans identified it was important to people living at Dick O'Th Bank Road to remain as independent as possible. People were supported by staff who knew them well and understood what was important to them. People's care plans identified their likes and dislikes. For example visit to family and friends. People relatives were able to visit when they wished and told us they had been kept informed of changes within the home.

People had developed trusting relationships with staff and were seen to use gestures or to lead staff to activities in the home they wanted to do. Interactions between staff and people found staff to be friendly and kind in their approach towards people, and people knew how to seek help when they required support. We observed staff treated people with patience and compassion. People were able to choose where to spend their time in the home, although the kitchen area was locked, because of identified risks, people were observed with staff in the kitchen when food was being prepared or if they wanted to have a drink.

People were treated with dignity and respect. When people received personal care this was done in the privacy of their own rooms. Staff were gentle in their approach and were led by the person's request for support.

People had personalised their bedrooms and were seen to enjoy spending time in their rooms. There were sensory items on the walls in the hall ways for people to touch as they walked past. Although televisions in people's bedrooms and communal areas were high on walls behind plastic screens, due to risk issues, if people wished the television to be switched on or turned over they sought the support of staff.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. Care plans reflected people's physical, mental, emotional and social needs their likes and dislikes. People's individual needs for social stimulation, community inclusion and access to group activities had been assessed but were not being met.

People were at risk of social isolation as they did not always have opportunities to participate in their chosen activities. Care plans stated it was important that people were being offered the correct level of interests important to them to stimulate them. Healthcare professional told us they felt improvements were required to the home's approach to person centred care. One health professional told us, "Although [person's name] seems fine they would benefit from going out on long trips with a variety of experiences. This used to happen but I don't think it has happened for a long time". Another health professional said, "We know that agreed activities have not been taking place, but following the recent reviews and the new manager in place we hope to reinstate these as soon as we can".

The provider's quality audits from February 2018 acknowledged that for one person the 'majority of the time has been inside the home watching television'. One person's personal profile stated that swimming was important to them. We were unable to establish through records or conversations with staff the last time the person had been supported to swim, go for a long walk or other activities they enjoyed. However we were informed their personal assistant had left in July 2017 and the person had not been able to follow their interests on a regular basis since then.

People did not always receive support that was personalised and responsive to their individual needs. For example during our inspection people were supported to go into the community for lunch. On their return we established due to a person requiring two to one support, they had not been supported in line with their assessed needs. Staff told us both people had been unable to access the community and had eaten their lunch in the vehicle. They told us they had limited resources to enable them to fully enhance people's quality of life, in line with their agreed care plans. One member of staff told us, "We need more staff who are able to drive to support people to go out and about". Following the inspection the operation manager told us that action had been taken to reinstate meaningful activities with additional staff being introduced to people.

The provider was not meeting the requirements of The Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The manager told us they had plans to introduce other resources, such as communication cards and boards. The manager told us, they had identified changes that needed to be implemented with immediate effect and had planned to work shifts to get to know people and staff. They told us, "Although I have been in post since February, I know communication is a key issue to address. I plan to visit another of our homes who have implemented new communication boards to observe and learn from them."

Information was not provided to people in an accessible way that was meaningful to them. For example, the

environment did not support their communication needs. There were no pictures or photographs of the daily activities which would be happening throughout the day or of who would be supporting them.

Communication passports explained what was important to communicate with people. One person's communication plan stated they responded well to objects of reference which was helpful for immediate choice making. Now and next cards had previously been used with the person. Their communication passport stated the person would take a card to staff if they wished to have a drink. We observed the person was able to take staff to the kitchen to indicate they wished to have a drink, but cards were no longer in place as identified in their communication passport, which identified to the person how many drinks they had received. A member of the speech and language team [SALT] visiting the home at the time of the inspection informed the manager it was important staff learnt to communicate with people through sign language as people living at the home had previously been able to sign. They agreed to organise some total communication sessions within the next few months.

On the second day of our inspection the provider informed us a new communication board had been ordered. They told us photos of daily activities and staffing would be used in the board to enable people to see what was happening, who would be supporting them and what activities would be taking place. They informed us referrals were submitted to the speech and language team for two people.

Arrangements were not in place to ensure people were fully able to share their views. At the time of the inspection, people were participating in reviews due to planned changes of the registration of the service. We observed one person being involved in their review. Communication needs for this person had not been identified that enabled them to fully participate in understanding the information that was being shared. The person's care plan had identified the person, needed the support of flash cards to enable them to fully understand what was happening.

Although the person was clearly happy to be involved in the review, formats such as photos, object of reference flash cards or PEC [a picture exchange system which is a form of alternative communication produced for individuals with autism spectrum disorder] was not used. These formats would have enabled the person to be more involved. PEC support people with limited cognitive ability to understand and exercise choice over what they are planning for how they live their daily lives. The operation manager told us, they had previous experience of managing the service and were aware the communication cards used had positive outcomes for people. They were unable to inform us why or when the communication aids had stopped being used. One member of staff told us communication cards had been lost and had not been used for a long time. Another member of staff told us, "It is urgent we start to use them again".

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

The service had a complaints system in place which captured complaints, reflected the steps taken to resolve them and also recorded any shared learning. There was a comprehensive complaints policy in place for staff and relatives and those we spoke to were aware of this. People relatives and professionals told us that they felt able to raise concerns and complaints and that were confident that or had experience of action being taken promptly.

People and relatives told us that they would be confident to raise any concerns in regards Dick O'Th Banks Road and felt that these would be listened to and acted upon. A relative said, "I don't have any complaints [relative's name] seems happy enough, but I would speak with the manager if I did." There were no complaints recorded at the time of the inspection, however the manager was able to demonstrate

knowledge on how to respond to complaints in line with the providers complaints policy.

Requires Improvement

Is the service well-led?

Our findings

The service had a new manager in place who had applied to become the registered manager of Dick O'Th Banks Road, they were also the registered manager of another of the provider's homes and planned to oversee both homes with the support of a deputy manager. The governance and leadership of the home did not always support the delivery of person centred care. The home had a number of audits in place that included care plan audits, fire safety, and weight tracker and communication techniques. There was also a home development plan to identify improvements. The home improvement plan completed in March 2018 stated that communication plans needed to be put in place for one person to aid drinks and choice making. Communication boards needed to be in place. These actions had not been completed at the time of our inspection.

Monitoring visits were completed quarterly by an operations manager, who also had the support of assistants who completed an audit on their behalf every six weeks. An audit by the provider in February 2018 contradicted the evidence we found during our inspection. The provider stated 'it was clear from direct observation from staff the correct communication techniques were being used'. It stated the provider recognised that choices were limited and did not reflect the communication profile of the person. The reviewer stated 'it was difficult to see what value other than basic life support the choices available were for the person'. They had identified that the person's records needed to be updated and realistic and achievable activities introduced and recorded on their on line system. They stated that there was no evidence to support how choices were being met, and action had been taken to amend the on line system to show how choices were being met. At our inspection the records remained out of date and communication aids were not being used.

Quality audits were not fully effective at identifying the shortfalls in the service we found during our inspection. Senior managers and members of the board of trustee completed formal and informal visits to the service. The operation manager told us the board of trustee completed two types of visits to the home, whereby one of the visits was based on asking specific questions around inspection questioning. They informed us if any issues were highlighted within the visits these were addressed with senior manager to action improvements.

Systems and processes had not reduced the risk of social isolation'. people were at risk of social isolation. One person's personal profile stated, 'that going out made them very happy on a one to one basis'. Staff told us joint trips in the car took place, their trip out was shared with another person living in the home. The provider's statement of purpose stated that 'a general sense that life is worth living and that there are future events and opportunities to look forward to for people living at Dick O'Th Banks Road. The evidence above demonstrates people were not being supported in line with the provider's statement of purpose.

Systems and process were not in place to ensure records were legible and up to date, and monitored and analysed by management. For example in relation to fire safety, the fire log book held the wrong information on who was living and working at the service. Cleaning rotas had numerous gaps, risk assessments stated that staff wore personal safety alarms when supporting one person. The record was recorded as up to date

in January 2018. One member of staff told us they started working at the home in the July 2017 and they had not known the alarms to be worn. We were informed the alarms, had not been in use since changes were made to who was living in the home. This meant that although records were being recorded as updated, the information inside them remained out of date.

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

The new manager was keen to drive improvement and learn from mistakes. Following our inspection, evidence was submitted that additional staff from the provider's domiciliary care service was being sought to provide two to one support with immediate effect to enable one person to access the community. Relatives confirmed that there had been a number of staff and management changes over the last year. The manager told us team leaders were changing within the next week and there had also been a new operations manager in post at the home since February 2018. They told us "It was time to move forward morale is mixed people don't like change".

The manager told us they were "Committed" to ensuring improvements took place. They told us they were reviewing roles including regular supervisions and appraisals by senior members of staff. They planned to establish links with other manager in regards best practice and told us they were, "Very committed to ensuring people living at Dick O'Th Bank Road had their identified needs met". Staff we spoke with told us, "Morale had been low" and said changes in management had impacted positively on the service. Some staff told us the current management team were approachable and felt they were making improvements. They informed us they were aware of plans to change from residential care to supported living, but were awaiting training on how to deliver the new support in line with best practice in meeting the requirements of supporting people living in a supported living environment.

Systems and process were in place to learn from other services. The operation manager told us, "We have identified communication training is an area we are lacking in overall. We are encouraging individual teams to manage their communication concerns. For example making contact with member of SALT team to update communication passports and make communication as bespoke as we can".

The provider had completed a Provider Information Return (PIR) prior to our inspection and, in this they told us, they received additional monitoring from their board of trustees. They stated 'The Board of Trustees are involved, they visit the home on a regular basis either announced or unannounced as part of our quality monitoring process. Following monitoring visits a report was shared with the board of trustees in regards, organisational risks and planned action to reduce risk.

The operations manager informed us following the last visit by the chairman of the board to Dick O,Th Bank Road on 26 May 2018, it was identified the provider needed to invest in supporting managers of their services to support each other through CQC inspections. They were therefore planning on investing in training managers to complete' mock inspections'. They said. "This way managers can learn from each other, set up peer monitoring, look at what you see and say what you see." The operation manager felt with the commitment and drive of the new manager improvement had already begun at Dick O'Th Bank Road.

It is a requirement that provider's display the rating we have given in a conspicuous place. The last Care Quality Commission (CQC) report was displayed in the home and on the provider's website. The provider is required by law to notify the CQC of important events which occur in the home to protect the safety of people who use the service and this was being done.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person centred care There were shortfalls in meeting people's needs and preferences in relation to designing care and treatment with a view to achieving service user's preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls in the governance systems at the home.