Young@Heart (Bernash) Care Home Ltd

Bernash Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Requires Improvement**
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

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Bernash Care Home provides personal care and accommodation for up to 23 older people. There were 21 people living at Bernash Care Home when we visited.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found there were shortfalls in a number of areas. Improvements were needed to ensure the service kept people safe and their rights were protected. Although people's needs were being assessed, their care plans lacked detail about the support they should receive. This meant people were at risk of receiving unsafe care.

Summary of findings

There were other failings in relation to care planning. The information in people's care records was not always up to date and there was a risk that people's plans did not reflect their current needs. It was not clear who had agreed the care plans as they did not show how people and their families had been involved in the process.

Many of the staff had worked in the home for several years and this provided continuity of care for people at the home. People spoke positively about the kindness of staff and how they were treated. Staff received training which helped to ensure people were effectively supported. However the care of people living with dementia was not planned and delivered in a way which was personalised to their individual needs.

The registered manager had implemented a number of changes since coming into post. However, suitable systems were not in place for checking and monitoring the quality of the service. This meant shortfalls in the service people received were not being identified and responded to promptly.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not safe in all areas. Some arrangements were being made for maintaining a safe environment, although parts of the home were not being checked well enough. This meant the service did not always keep people safe.

Risks to people were being identified. However, there was a lack of guidance for staff about how to reduce risks and to protect people's rights. Accurate and up to date records were not always being kept. This meant people were at risk of receiving unsafe care.

People told us they usually felt safe in the home and that staff were available when needed. Staff knew how to recognise abuse and understood the need to report any concerns. However the requirements of the Mental Capacity Act 2005 were not being met and there was a risk people were being deprived of their liberty without the necessary authorisation.

Is the service effective?

Requires Improvement

The service was not consistently effective. People mostly enjoyed the meals and we saw people being well supported at lunchtime. However, there was a risk people would not always receive the support they required with nutrition and fluids to maintain their health.

Staff received training which helped to ensure they supported people effectively. Staff were aware of risks to people's health and wellbeing. Arrangements were in place for people to receive the support they needed from healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring. People spoke favourably about the care they received and the kindness of staff. However we found care was not always planned and delivered in a personalised way which took account of all aspects of people's lives.

Staff supported people in ways which helped them to maintain their independence. Their relationships with the people they cared for were friendly and positive. Staff mostly spoke about people in a respectful way. However, this was not consistent and some comments made by staff did not reflect a positive approach towards supporting people living with dementia.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. There was a lack of involvement by people in the development of their care plans. The information in the care plans was not always up to date and reflect people's current needs. This meant there was a risk that people would not receive the care they required.

Summary of findings

Some people were able to follow their own interests and routines. One person, for example, told us they enjoyed reading and having visitors. However, other people were more dependent on staff who had limited time to support them with social activities and to ensure their social needs were met.

Is the service well-led?

Inadequate

The service was not being well led. In particular, systems in place for checking and monitoring the service were not well developed. This meant shortcomings in the home and the service people received were not always identified and responded to promptly.

People and staff had mixed views about changes that had been made in the running of Bernash Care Home and their impact on the home. Some people felt that the management style was now less open and approachable.

Bernash Care Home

Detailed findings

Background to this inspection

We inspected Bernash Care Home on 17 July 2014. This was an unannounced inspection. The inspection team consisted of an inspector and an expert by experience. The expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited Bernash Care Home we checked the information that we held about the service and the provider. We looked at the notifications we have received about the service. A notification is information about important events which the service is required to send us by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At our last inspection in November 2013 we checked whether improvements had been made in relation to staff training and support. We found that they had.

We spoke with eight people at the home and with two relatives who were visiting at the time. We also spoke with five staff members and with the registered manager. We met with a GP from a local surgery who was visiting people at the home. We observed people receiving support from staff and looked around the premises. Three people's records were looked at, together with other records relating to care and the running of the home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

We found that improvements were needed to ensure people using the service were safe and their rights were protected. Where procedures were in place for maintaining a safe service, these were not always being followed in a consistent way.

There was a lack of documentary evidence to show suitable arrangements were being made to protect people when they lacked capacity to make informed decisions. Staff knew about people who lacked capacity. However, people's care records lacked information about the assessment of their mental capacity and how decisions about care were being made when people were not able to give their informed consent. This meant people could not be confident that decisions were being made in their best interests. The arrangements were not meeting the full requirements of the Mental Capacity Act 2005. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

Sufficient action had not being taken to ensure the risk of a person's liberty being deprived unlawfully was minimised or followed up with an application to the appropriate authority for approval under the Deprivation of Liberty Safeguards (DoLS). The DoLS provides a process by which a care home can deprive a person of their liberty in a correct way when this is in the person's best interests and there is no other way to look after them safely. The registered manager told us an application was being considered in relation to one person. However, care plans for people who lacked capacity had not been reviewed as part of a process to determine whether there was a deprivation of the person's liberty. The reviews were therefore needed in order to establish whether there were restrictions on people's freedoms and if these were lawful. This meant appropriate steps were not being taken to remove the risk of a deprivation of liberty where possible.

In one person's care record it stated they spent most of their day 'walking around the home asking either to go home or to be let out of the building'. We talked with staff about this and were told that the person lacked capacity to make decisions relating to their care. There was no information in the person's care plan to guide staff about how to respond to this person's actions. We heard from staff that they took different approaches in response to this person's actions. There was a risk that this person would not be supported in a way which was safe and which did not restrict their liberty.

The home's policy on restraint did not provide clear guidance for staff. The policy stated it was "not permitted to cause unnecessary physical restraint or intervention on a service user" and only in the "best interest of the service user may any kind of intervention or restraint be permitted". The use of terms such as "unnecessary" and "best interest" meant the policy was open to different interpretation. There was a risk intervention or restraint could be used inappropriately, although the registered manager told us that no form of restraint was being undertaken.

There were shortcomings in the procedures for assessing risks to people and for the planning of support to reduce these. In one person's care plan for 'falls' it was stated they 'have had falls in the past'. There was no information in their care plan about the reasons for the falls and the support they needed to maintain their safety. Other records, such as assessments of people's needs in relation to moving and handling, had not been completed or lacked detail. This meant people were at risk of receiving unsafe care because accurate and up to date information about their needs was not available.

We found shortcomings in relation to risk and safety in the home. In the Provider Information Return (PIR), we were told that 'environment checks are monitored and acted upon' and that cleanliness in the home was being monitored. During our inspection we found aspects of the environment were in need of improvement. Some areas of the home had not been cleaned to a good standard. These included a toilet that had not been adequately cleaned during the day and the pull cord to the light in a bathroom had become very dirty over time. Used disposable razors had been left on a shelf in another bathroom.

Some arrangements were in place for ensuring items in need of repair or maintenance were followed up. For example, a maintenance book was kept in which staff reported items in need of attention. A schedule had been produced for the servicing of equipment such as the home's lifts and portable hoists. The maintenance

Requires Improvement

Is the service safe?

schedule showed the home's emergency call system was being serviced every six months. One person told us they used the system and said, "If I need anything I push my button and the staff reply quickly".

However, we found the arrangements did not ensure that a safe environment was maintained in all areas. We saw for example three wall lights on landings were not working. It was particularly important to have good lighting in these areas as there was a staircase nearby. It was reported in the PIR that fire checks were being carried out weekly and recorded. However when we looked at the record of weekly tests of the fire alarm system we saw the last test had been carried out on 25 May 2014. We brought these matters to the attention of the registered manager who told us they would be followed up.

There were enough staff working at the home to keep people safe. People told us they felt safe because the staff were available to help them. One person commented "The girls walk up and down in the corridor all night so if I want anything I only have to shout out." The registered manager told us staffing levels were primarily based on the number of people who used the service. They said dependency levels were also being assessed to identify when additional staff were needed. This helped to ensure staff were deployed in sufficient numbers to meet the needs of the people who used the service.

Staff said said there were more demands on their time in the afternoons and in the early evenings. One staff member commented that some people became "noisier and more agitated" at these times, which meant they had to spend more time supporting people directly to ensure their safety. Staff felt however the staffing levels were being maintained at a level which was safe for people. We saw staff were available to monitor people's safety in the communal areas and to provide assistance when needed. A staff member said they made sure there was someone "on the floor to keep an eye on people". Staff were deployed to work in different parts of the home and they checked on people who were in their own rooms.

It was reported in the PIR there had been no changes in the staff team during the last year and no use of agency staff. This meant no new staff had been recruited. The registered manager confirmed the checks that needed to be undertaken to ensure new staff were safe to work with the people who used the service.

People were protected from the risk of harm because staff were aware of their responsibilities in relation to safeguarding people from abuse. We saw records which confirmed staff had undertaken safeguarding adults training. Staff we spoke with were aware of how to report any concerns they had about people's safety or people being at risk of harm. They knew if they suspected abuse, they had a duty to ensure it was reported to their manager. The arrangements for safeguarding people from abuse were also confirmed in a written procedure.

Staff were aware of risks to people's safety in connection with their individual needs and how these could be reduced. This included, for example, the use of bedrails and the need to regularly check they were working correctly. We saw people using aids to assist them with walking and when getting in and out of chairs. Staff said they assessed how much 'hands on' support people needed at the time, as this could vary from day to day. This showed the staff were concerned about people's safety but also understood the importance of people maintaining their independence.

Requires Improvement

Is the service effective?

Our findings

There were shortfalls in the arrangements being made for supporting people with eating and drinking. In people's care records, we saw their needs had been assessed and care plans produced in relation to nutrition. This helped to ensure people at risk were identified and they would receive the support they needed with their food and fluid intake. However there were shortcomings in the arrangements because of a lack of accurate and up to date information in the care plans.

In one person's care plan for "diet and weight" dated 29 November 2013, it was stated "I have a small appetite and will need full assistance. My daughter usually comes in to help with my food intake". However, there was conflicting information in the record of a nutritional review dated 31 May 2014. This meant the person's care plan for diet and weight did not reflect their current needs or provide guidance for staff about how to support this person effectively with their food and fluid intake. This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

In addition to looking at records, we spoke with the person and one of their family members, who was involved in supporting them. There was a lack of agreement and information about how staff and family members worked together to meet this person's needs, for example how best to assist them with their nutritional intake. Daily charts did not provide a good record of the person's food and fluid intake to show how this was being managed on an on-going basis.

Other people were able to eat and drink independently, or with varying degrees of support from staff. At lunchtime, we saw staff being attentive to people's needs. Some people received individual assistance with their meals from staff members who sat beside them. Staff helped each person at a pace which suited them, although we observed people were not offered a drink between mouthfuls. One person who was able to manage their meal by themselves initially then received encouragement and offers of support when staff judged this to be needed. This showed staff were supporting people in a way which helped them to maintain their independence. We observed however another person complained that their food was too hot and nobody had warned them of this.

The meals we saw looked appetising and well presented; portion sizes were appropriate. The menu did not show a choice of dishes although staff told us alternatives to the planned meal were provided if needed. When staff noticed one person wasn't eating their meal we heard the person being asked if they wanted something different. The person chose a sandwich and was then asked what filling they would like. This showed staff were aware of the importance of ensuring that people maintained their nutritional intake.

We heard mixed views from people about the quality of the meals. Most were positive, with comments such as "the food is very good here and plenty of it, and we get plenty of cups of tea." We also heard the food was "not so good now" and one person told us "we had better food before but this is ok." We saw drinks were readily available to people during the day. The chef told us they were aware of people's likes and dislikes and had been given information about dietary needs. Staff said that alternatives to the set meal were provided if needed. However, these arrangements meant people were not being offered a choice of courses in advance of the meal.

A staff member told us concerns about a person's nutrition and weight loss had been followed up with a visit from the GP. We were told changes in the meal arrangements were made which meant the person's food intake improved. The registered manager said a dietician had been involved with one person. However, this was not consistent; we talked to the registered manager about another person who would benefit from the involvement of a dietician although this had not been arranged. On the day we visited, four members of staff were attending a training session led by a dietician. This helped to ensure the staff would have a better understanding of people's dietary needs and how to support people effectively.

When talking about the staff, one person commented "they are definitely well trained". A relative commented "Generally I can't fault the carers, they know my relative very well, their ways, needs and idiosyncrasies". A programme of training was being implemented which included subjects relating to health and the care of older people. Records showed the registered manager was monitoring the training staff received. Staff said they had

Requires Improvement

Is the service effective?

received the training they needed to support people effectively. They told us this included dementia awareness training. Staff said they would benefit from more training in relation to dementia, as they felt "increasing demands" were being put on them as more people living with dementia were being admitted.

Staff were aware of risks relating to people's health and welfare. One staff member, for example told us they recognised that redness on a person's skin was a concern, as it could indicate tissue damage due to pressure. Staff said they reported any concerns to a senior and they felt that people's GPs were being contacted appropriately to ensure any concerns were followed up promptly. We met with a GP during our inspection who told us they had a good working relationship with the service.

Requires Improvement

Is the service caring?

Our findings

Care plans did not reflect people's own views or set out their individual preferences. There were sections in the care plans, such as "What do I like/want?" and "What is important to me?" although these sections were blank or had not been completed in any significant detail. One person, for example had a care plan for Communication, however the only information recorded was "My communication is poor". There was no information in the care plan to inform staff in what way the communication was poor and how staff should communicate with this person. This meant there was a risk staff would not communicate with the person in a way they preferred and which met their individual needs.

Staff used people's own name and terms of endearment were used appropriately. At most times we heard staff speaking to people in a friendly and caring manner, and giving people time to respond to what they were being told or asked. During our observation of the meal however we heard staff refer to people who needed support with eating as "feeders". A staff member also called across the room to another: "I can't get any more into (person's name)." This showed a lack of respect towards these people.

People who used the service told us that the staff were kind and they had good relationships with the staff team. One person, for example, commented "The girls are marvellous; they do so much for me; they are respectful and look after me very well; very tactful and there's always a cuddle". Another person told us "I make the best of it here, you have to; I thought I was coming here for the end, and look at me - still here, thanks to these kind people."

Relatives we met with also spoke about the kindness of staff. One family member said that they had built up a close relationship with staff who had cared for their relative for some time. Another visitor told us "Generally I can't fault the carers, they know my relative very well, their ways, needs and idiosyncrasies. Staff are respectful when giving personal care and talk to my relative throughout." We heard from relatives that they were made to feel welcome and could visit the home at any time.

Staff members also felt they had established good relationships with the people they cared for. Staff said their knowledge of people had developed over time. One staff member commented after working for several years at Bernash Care Home they would now find it difficult to leave and no longer care for people at the home.

People looked well supported with their personal appearance. Their footwear and clothing looked appropriate and suitable for the weather at the time. Not everybody was able to express their views verbally and we observed how staff members engaged with people. Interactions with staff and people at the home were friendly and respectful, other than in relation to the language used by staff on occasions. People's body language indicated they were relaxed and comfortable in the company of staff.

Inadequate

Is the service responsive?

Our findings

Improvements were needed to ensure people received a service that was responsive to their needs. We found there was a lack of involvement of people in the development of their care plans and they did not reflect people's current needs.

The registered manager told us in the PIR they ensured the service was responsive by 'involving people who used the service and their families in their assessments and care plans'. It was also reported that any changes involving the person would be recorded in their care plan.

This approach however was not evident from the care plans we looked at. In the care records there was a statement the care plans were to be fully reviewed every six months. However there was no record to show that reviews of two people's care plans dated November 2013 had taken place after six months. The registered manager confirmed it was the intention to review the care plans every six months or more often if a person's needs changed. They acknowledged however that this timescale had not been followed and where care plans had been reviewed, this was not clear from the records.

The registered manager also told us the care planning system included a range of evaluations and reviews to be undertaken and recorded on a monthly basis. People's care records included forms for the recording of monthly evaluations of care and reviews of people's needs. These were not being completed on a consistent basis. For example, there was no record of a monthly evaluation of one person's care and wellbeing after March 2014. This meant there was a risk that changes in the people's needs were not being identified and action taken to ensure these were met.

Care plans did not provide staff with good information about how to respond to people's individual needs. For example, one person's care plan stated they needed "full assistance with personal care" and another "I will need complete help with personal care". There was no information in the care plans about how this assistance was to be provided or, in relation to one person, the particular arrangements being made for the provision of end of life care. One person's care plan for Mental state and cognition stated they had been diagnosed with having temporal lobe epilepsy. There was no information in the care plan about how this affected the person's mental state and cognition, or how to keep this person safe should they have a seizure. This meant there was a risk they would not receive the care they required as proper information regarding their needs was not available in their care plan for mental state and cognition.

In one person's care plan for social interests and hobbies it was stated "I am unable to take part in activities. I like to spend most of my time in bed in my room". There was no information or guidance for staff in the care plan about how staff should engage with this person to ensure their social needs were met and they were not isolated.

As reported in this and other sections of the report, we found care records were not always accurate and or have appropriate information in relation to people's care. This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

There were no planned activities on the day of the inspection although staff said an entertainment session was provided on alternate weeks. We were told a volunteer also came in for one and a half hours a week to help with activities. During our inspection we observed some people were able to occupy themselves. Other people had little social interaction with staff and spent time in the same seat in the lounge, where they were also served their meal at lunch time.

People expressed mixed views about routines in the home and how they could spend their time. One person told us "This place is not perfect but it is OK, I would like better food, more activities and the opportunity to go out, although it doesn't bother me too much." Another person commented "I get fed here but manage everything else myself". Comments from other people showed they were able to follow their own interests and routines. One person told us they enjoyed reading and having visitors.

Staff told us about the range of needs of the people who they supported. This included people who were independent in many areas, as well as other people who needed a lot of support, including end of life care. One staff member commented they organised activities "when time allows" but they also had to prepare tea and if they were short on time then "the care comes first".

Inadequate

Is the service responsive?

We also heard from staff that it could be difficult to spend time on activities later in the day when it was more difficult to engage with those people who became more "restless" at that time. A visitor to the home told us that although there were usually enough staff in the morning, it was more difficult for staff to respond to people's needs in the late afternoon and evening. One person who used the service commented "Staff are lovely, but they are rushed off their feet; new residents have different needs and need more help so we don't have the same care as before." This meant there was a risk that the quality of care was affected because of changes in people's needs at the home.

Some arrangements had been made for people to express their views about the home although there was no systematic approach. A meeting with relatives and people living at the home and also with staff had taken place in February 2014. Questionnaires had then been sent out, although the registered manager told us the results of these had not been analysed. This meant people had not been informed of the outcome and how their views had contributed to the development of the service. The feedback we received showed that people were not aware of when further meetings would be held and they would be able to pass on their views.

In the PIR it was reported the responsiveness of the service was to be improved by increasing 'the input from families and finding another way which we can do this rather than by phone or email'. We were told there had been one relatives and residents' meeting in the last 14 months, which one person said had been an opportunity for them to "air their views". People's comments indicated they would like more occasions to meet and to discuss developments affecting the home. People told us that they were aware of who they could talk to if they had concerns and how to make a complaint. Records we saw showed that where complaints had been made, these had been responded to by the registered manager promptly and in writing to the complainant. There was no system in place for monitoring complaints and other concerns to identify trends and ways in which the service could be improved.

Inadequate

Is the service well-led?

Our findings

Improvements were needed to ensure that people benefited from a well-run home. In particular, we found suitable systems were not in place for checking and monitoring the standards in the home.

It was reported in the PIR that monthly audits in relation to care plans, risk assessments, the environment, staff training and medicines had been introduced in June 2014. We were told in the PIR that 'outcomes will be action planned'. We found however this system for assessing and monitoring the quality of the services provided was not yet in place. Risks to people's safety within the home were not always being identified and reduced. The registered manager told us the system of internal audits, as reported to us in the PIR, had been planned but not yet started.

We saw records of an audit that had been undertaken in relation to the assessment and care planning documentation by an external company in May 2014. The findings of the audit showed there were shortcomings in most areas that were assessed. These included no evidence of personal choices in the care plans, or evidence of family or advocate involvement where the person had been assessed as lacking capacity. There were also failings in the recording of risk assessments for medicines.

There had not been a response to the failings identified in the audit. We saw there continued to be shortcomings in the care records, including the same problems identified in the external report. Concerns about the care records had also been identified and brought to the registered manager's attention by a quality assurance officer from Bristol City Council during visits they made to the home earlier in 2014. This showed an effective system was not in operation for improving the care records and for reducing the risks to people associated with a lack of accurate records.

The registered manager had introduced new documentation to improve the planning and recording of people's care. However they acknowledged the records were not being completed appropriately and said more needed to be done to involve the staff team in the process. They told us some staff had found it hard to adapt to changes in the daily routines and also to the new management as a whole.

Our findings during the inspection showed that an effective system for assessing and monitoring the quality of the service was not being operated. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

In addition to the registered manager, there was a deputy manager who had been delegated a range of tasks, including the supervision of staff. Not all the staff however felt that they had been supported through the changes they had experienced at the home. We met with staff who felt there was a need for more support and for better information about recent developments. Some people felt that the management style was now less open and approachable.

Staff were aware of how to whistle blow; they understood it meant they were protected in law, if they as an employee reported unsafe or illegal practices at work. This helped to ensure people were protected from harm because staff knew what action they could take if they had concerns.

The registered manager wrote a report for the provider each month to update them on developments in the home. This helped to ensure the provider was aware of changes affecting people at the home and staff, and the occurrence of any incidents and significant events. We were told in the PIR that a director from the company (the provider) visited the home approximately twice a month. This meant that a representative of the provider was able to gain a view of the service at first hand. However there were no reports available to show the outcome of the visits and how improvements were being made based on the feedback received from people at the home and from staff.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person was not making suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to assess and monitor the quality of the service provided.**

The enforcement action we took:
We have issued the registered person with a warning notice which requires them to become compliant with Regulation 10 (1) by 19 September 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People were not protected from the risk of unsafe or inappropriate care because accurate and appropriate records were not being maintained.**

The enforcement action we took:
We have issued the registered person with a warning notice which requires them to become compliant with Regulation 20 (1) by 5 September 2014.