Care Quality Commission

Mr Diwan Suresh Chand

Highcroft Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out this unannounced inspection on 31 July and 7 August 2015.

We last inspected the home on 25 January 2014. During this inspection we found a breach of one regulation. People were not protected from the risks of inadequate nutrition because their needs were not adequately assessed and managed.

Highcroft is a care home without nursing that provides residential care for older people and people living with dementia. It is registered for 23 people but at the time of this inspection there were 18 people on the first inspection day and 19 people on the second inspection day using the service. The home is spread over two floors and the upper floor is accessible by a lift.

The service did not have suitable arrangements in place to ensure that people consistently received their medicines safely and as prescribed. Food was not always stored and rotated to ensure it was safe to give people to eat. Several areas of the home were dirty and in need of refurbishment and infection control procedures were not always followed.

Summary of findings

Staff were knowledgeable about the procedures relating to safeguarding. People had an assessment of their needs and risk assessments were carried out to ensure safe treatment and care was provided. Safe recruitment checks were carried out.

Staff received supervision and opportunities for training and skill development. Staff told us online training was provided but they would appreciate more opportunities of group training and to use supervision and team meetings to develop their learning. The registered manager and staff were knowledgeable about the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People had a choice of food from varied and nutritious menus. Not all staff were skilled at ensuring people had sufficient amounts of food to eat and liquids to drink. Staff knew how to deliver personalised care. There were activities on offer but these did not always take into account people's personal preferences. People had access to health care professionals as required to meet their day-to-day health needs.

Staff were knowledgeable about how to maintain people's privacy and dignity and enabled people to maintain their level of independence. People and their representatives knew how to make a complaint and these were dealt with appropriately and in accordance with the timescales laid out by the policy.

At the time of our inspection there was a registered manager at this home. 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.

The provider did not have effective systems in place to check the quality of service provided. People and their representatives were able to give feedback through surveys and meetings. However, there was no evidence that issues identified were acted upon to improve the service. Staff attended regular team meetings to receive updates and guidance on the service. However, staff told us they would like to team meetings to happen more often.

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

The overall rating for this service is "Inadequate" and the service is therefore in "Special measures". Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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 always safe. The provider did not have effective arrangements in place for the administration of medicines which meant people did not always receive their medicines safely and as prescribed. Medicine supplies were not always stored appropriately and safely.

The provider did not have effective systems in place for the safe storage and rotation of food products to ensure they were safe for people to eat. There was not a consistent standard of cleanliness throughout the home.

Staff were knowledgeable about the safeguarding policy and knew how to report concerns or abuse. Safe recruitment checks were made. People had risk assessments and plans to manage risks.

Is the service effective?

Good

The service was effective. Staff received regular supervisions to ensure they delivered good quality care. People received care from staff that were trained to deliver care. However, staff said they would benefit from more classroom based training as the majority of training was delivered online.

The registered manager and staff were knowledgeable about mental capacity and deprivation of liberty. Staff explained how they sought people's consent before delivering care.

People were given choices of suitable and nutritious food and drink to protect them from the risks of inadequate nutrition and dehydration. Not all staff were skilled at encouraging people to eat and drink sufficient amounts.

The home worked together with health professionals to ensure people received care appropriate to their needs.

Is the service caring?

Good

The service was caring and there was calm and relaxed atmosphere in the home. Staff had developed positive relationships with people and had a good understanding of their needs.

Staff spent time interacting with people and spoke to them in a polite and caring manner.

People were treated with respect and their privacy and dignity were promoted. Staff encouraged people to maintain their level of independence.

Is the service responsive?

Requires improvement

The service was not always responsive. People said they did not have enough to do and their preferences of activities were not always considered.

Summary of findings

Care plans were comprehensive and were personalised to each individual. Care plans were reviewed regularly and updated when people's needs changed.

People and their representatives knew how to make a complaint and these were responded to according to the service policy.

Is the service well-led?

Inadequate

The service was not always well-led because although there was a registered manager in place, there was not always a senior manager available to support staff.

Quality assurance systems were not used to help the service improve. There was no action plan to follow feedback surveys received from people and their representatives. The registered manager and provider did not record their quality audits and no action plan was in place to follow up identified issues.

The provider had meetings for people who used the service but there was no evidence that issues identified were acted upon. Staff meetings were held and focussed on performance issues within the team. Staff said they would like to have more frequent meetings.

Record-keeping was disorganised which made it difficult for staff to ensure they provided safe and consistent care to people.

Highcroft Care Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 31 July and 07 August 2015. The inspection was carried out by two inspectors and an expert-by-experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. Two inspectors carried out the second visit.

Before we visited the service we checked the information that we held about the service and the service provider. This included previous inspection reports, details of its registration and any notifications they had sent to the Care Quality Commission (CQC). We usually ask the provider to complete a Provider Information Return (PIR) before the inspection. 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. However, due to receiving concerns about the service prior to this inspection, the provider was not asked to complete a PIR. We obtained this information during the inspection instead. We received concerns from a whistleblower, a professional who visited the service and a member of the public, relating to the care which people received.

During the inspection we spoke with 5 people who lived in the home, one relative, 4 staff and the registered manager. We observed interactions between staff and people living in the home and observed care and support in communal areas. We looked at care and management records including three staff files five people's care records, records relating to maintenance and medicines, the complaints folder, policies and procedures for the service and minutes of meetings.

Inadequate

Is the service safe?

Our findings

The service was not always safe. We checked the medicines administration records (MAR) for six people and looked at the arrangements in place for storage and management of their medicines. We found the service did not have suitable arrangements in place to ensure that people consistently received their medicines safely and as prescribed. For example, one person's MAR sheet showed staff had signed to show they had given a tablet but the tablet was still in the blister pack. This meant the person did not receive their medicine as prescribed.

There were temperature recordings for the room in which medicines were stored as well as for the medicines fridge. We found no record had been entered for the day prior to our inspection and in some cases the temperature of the room exceeded the recommended maximum of 25°C. We also found medicines that had been opened were not always labelled with an opening date. This meant that staff could not tell if the medicines would still be effective and if they would be fit for use.

We saw the controlled drugs cabinet was not fitting tightly to the wall as is required by the Misuse of Drugs (Safe Custody) Regulations 1973. In the controlled drugs cabinet there were two bottles of a liquid medicine prescribed for one person but only one bottle was accounted for in the mandatory stock recording book. Staff told us, "The person has just come out of hospital so the pharmacist gave us some extra in case [person] needed it." It was not clear why the pharmacist had done this or why it had not been recorded. This meant it would be difficult for staff to know if a bottle of this medicine was to go missing or to work out if the person was receiving their medicine as prescribed.

There was a large quantity of medical supplies including dressings, catheter tubes and syringes which were stored in unlocked filing cabinets in a room that people had access to. Many of these products were significantly out of date and some had the protective seal broken. We saw there were sharps boxes also stored in this room of which one was open and still in use. Staff told us the medical supplies were for the district nurses to use when they visited. This meant people were at risk of injuring themselves or others if they picked up any of these medical supplies.

On the second day of inspection we reviewed the arrangements for storing food products and found stock rotation was not done. This meant there was out of date food in the kitchen, the fridges and in the cellar where excess food was stored. Records for the fridge and fridge temperatures for July 2015 were not available for us to check that food was being stored at the correct temperature. Shelves in kitchen cupboards and in the fridge in the cellar where food was stored were dirty.

In the kitchen, we saw opened food had a date but the cook was unable to tell us if this was the opening date or the use by date. Bread taken from the freezer to defrost was not labelled to show either the date of freezing or the use by date. The food cellar smelled strongly of damp, paint was peeling off the walls, mould spores were growing on the walls and the floor covering was lifting off the floor. We found some dry foods stored in plastic containers were out of date and other dry foods that were opened were left unsealed on the shelves in the cellar. We spoke to the manager about this who took immediate action to remove all foods that could not be safely eaten. Since the inspection, the manager has told us the cook has moved on from this employment.

During the inspection we found several areas of the home were dirty and in need of refurbishment which meant people were not protected from infection. We saw visible dirt on the toilet brush and holder in one of the bathrooms, cobwebs hanging from a window and from a fire extinguisher and there was a smell of urine in several areas. We also saw that the encasing of sinks in two people's bedrooms looked dirty and in need of replacement, a toilet with a broken cistern and the bath which was used most often by people was dirty and chipped.

On the first day of inspection, people were not encouraged to wash their hands before or after eating and no napkins or hand wipes were provided. We observed one person had their hair dried next to the dining room table and staff did not clean or disinfect the area before serving lunch. There were trip and hygiene hazards in the garden area. For example there was disused furniture, and the alleyway was blocked with bins and discarded mattresses. Since the inspection the manager has provided evidence to show trip and hygiene hazards have been removed from the garden area.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Inadequate

Is the service safe?

2014 because at the time of inspection the provider did not have effective arrangements in place for the safe management of medicines, the safe storage of food products or for keeping the environment safe and clean.

A family member told us their relative was definitely safe at the service. The provider had a safeguarding policy which was comprehensive and gave staff guidance on recognising abuse and how to report it. The training matrix showed staff had received training in safeguarding. Staff we spoke with were able to describe what abuse was, how they would document concerns and report it to the manager.

Care records showed that risk assessments were carried out for people including for room security, mobility, manual handling and pressure sores. Risk assessments detailed people's abilities and what support they needed to stay safe. For example, risk assessments carried out for people who were at risk of falls had guidelines for staff to seek help from a senior person before trying to move them. Staff were able to describe measures in place to support people who were at risk of falling including encouraging people to use mobility aids.

Safe recruitment checks were made. We looked at the recruitment records for four staff and found that all pre-employment checks had been carried out as required. Staff had produced evidence of identification, had completed application forms with any gaps in employment explained, had a disclosure and barring service (DBS) check, and where appropriate, there was confirmation that the person was legally entitled to work in the UK.

Good

Is the service effective?

Our findings

Staff told us they received supervisions and explained that during these meetings the manager gave their views and the staff member had an opportunity to reply. We saw from staff records that staff received regular supervisions every two months and the topics discussed included the staff member's strengths and weaknesses, training completed, training needed and work performance. Staff told us they would like to use their supervisions to develop their learning.

The registered manager told us new staff received a one week induction where they shadowed experienced staff and had to complete a three month probation period which could be extended if needed. The registered manager also told us staff had completed the Skills for Care Common Induction Standards. The Common Induction Standards is training in an identified set of standards of care that staff receive before they begin working with people unsupervised. We saw this was the case when we checked people's training records and we saw training courses included dementia care, person-centred care and behaviours others may find challenging.

Not all staff were trained on the administration of medicines, and staff explained that the registered manager respected if they did not feel confident to do this yet. We noted that training was provided to staff in an online format with a knowledge assessment on completion. Staff explained that new staff received a practical session in moving and handling from experienced staff when they had completed the online training in this topic. Staff also told us they would appreciate more face to face training to help them to learn. One staff member said they were being supported to study for the national vocational qualification at college and found the classroom based teaching effective.

The registered manager and staff demonstrated they understood the Mental Capacity Act 2005 (MCA), associated codes of practice and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived. The registered manager understood the importance of identifying people whose liberty was deprived. At the time of this inspection there were DoLS in place for the majority of people using the service. However, the registered manager was not aware they needed to inform CQC of these.

We saw that staff had arranged best interests meetings with appropriate professionals when they had applied for a Deprivation of Liberty Safeguards authorisation. Where people had DoLS in place, staff had updated their care plans appropriately to reflect this restriction. This meant that people were not being deprived of their liberty unlawfully.

Staff told us how they sought consent for care tasks, support with eating and medicines. For example, one staff member described how they checked with people at each stage of medicines administration including explaining what medicines were for if the person was not sure. Another member of staff explained that they seek consent because "I look at myself and think how would I like it?"

We saw care records contained basic details about nutrition and hydration. However none of the care records reviewed included people's preferences relating to food and drink. We looked at food and fluid charts that were kept for people at risk of malnutrition and found them to be detailed and used effectively to monitor daily intake. One person had been noted to have lost weight but it was not clear if any action was needed.

A family member told us, "The food feels good, they vary everything." One person told us, "I enjoy my grub, we have egg & chips or sausages & chips or stew with dumplings." However we found that not all staff were skilled at encouraging people to eat and drink sufficient amounts. We observed the lunch service on the first inspection day and saw people were offered juice but this was not provided in jugs and we saw some people had to wait to be given more juice when they asked for it. A staff member was seen serving lunch in silence, placing a plate in front of each person and then walking away without speaking. We noted one person did not eat their lunch and had pushed their plate away. We asked a staff member about this who said this person often did this but the staff member did not talk with the person to find out if they wanted a different meal. We also noted that when people were halfway through their meal, the staff member placed a bowl of dessert next to them without asking if they wanted dessert of if they would like a break before their next course.

Good

Is the service effective?

The lunch service had improved on the second inspection day and we observed staff interacting with people in a friendly and jovial manner. On both inspection days we saw people were able to choose where they wanted to sit to eat their meal. For example, we saw people chose to eat in the lounge, dining room or in their bedroom. We also observed staff asking people in the morning what they would like to eat for lunch. We looked at three weeks of menus and saw they were varied and nutritious. Staff explained that if people did not want what was being offered they "Always try to offer something else." We saw that people's choices were recorded on daily record sheets.

The cook told us they wrote the menu every week and the registered manager approved it. The cook also said the residents are "always asked what they prefer," and if they changed their minds they were offered an alternative. Staff were knowledgeable about individual diet requirements. The cook told us people with diabetes were offered different choices of desserts, for example, fresh fruit or yoghurt. Staff told us one person had a pureed diet and that information about this and the exact consistency was in their room; "It's on the wall, you can't miss it." Staff described how another person had been assessed by a dietician and speech and language therapist and now used a thickener for their drinks.

The registered manager told us a community dentist visited the home yearly to check people's oral care and there was an ongoing programme of scheduled home visits by the community optician and chiropodist. Staff told us that they supported people to medical appointments and made records of what happened so families could be kept up to date. Care records showed that when there were concerns people were referred to appropriate healthcare professionals. We saw evidence of staff being proactive in liaising with health professionals, including GPs and chiropodists, in people's care records.

Good

Is the service caring?

Our findings

We found the service was caring. A family member told us they had good communication with staff and the registered manager. The family member told us, "They always tell us what is going on", and "It's easy to contact them." The family member also said that their relative was offered choices "at least when we're here." We asked this family member if they thought the service was caring and they said, "They really take care of [relative's] conditions, it's adapted for older people."

There was a calm and relaxed atmosphere in the home. Staff described how they developed positive caring relationships with people by reading care plans and how the best way was to spend time with people and "sit and have a chat." One member of staff told us that there was not always the time needed to give people dedicated one to one time but that they, "Try to do as much as I can throughout the day." Staff demonstrated they had a good understanding of people's personal preferences and history.

We observed staff speaking to people in a polite, respectful and caring manner. Staff spent time talking to people and reminiscing about their past and people seemed to enjoy talking to staff about their favourite television programmes. We saw people smiling and sharing jokes when staff spent time conversing with them. We also noted that one person who had just been discharged from hospital was thrilled to be welcomed warmly by staff on their return. This person sat and talked to staff about how happy they were to be back. We saw a member of staff assisting another person to dry their hair and both were chatting away to each other whilst this task was being done.

On the first inspection day we noticed the lounge was very hot with no natural ventilation or fans. It was a warm sunny day and the radiators were switched on. Staff told us the heating was on to help dry people's clothes. We spoke with people who were sitting in the lounge who said they were too hot. Staff turned the heating off when we raised this with them.

On the second inspection day we observed a member of staff offering to support one person, who was tired, to go to their room for a lie-down. The person responded by saying, "You work too hard", and we observed the staff member used their skills in persuasion to convince the person that it was no trouble to support them. The staff member continued to reassure the person as they left the room.

A family member told us that staff respected people's privacy and dignity and, "They ask us if we want private time or to go in the garden. We really appreciate it. They know us well." The registered manager told us that people could have privacy with visitors in the conservatory area if they wished. Staff demonstrated a good understanding of how to maintain people's privacy and dignity while delivering care. For example, staff described how they talked to people throughout care tasks ensuring they are aware of what is happening at each stage and ensuring the door is closed when supporting people with personal care.

Staff told us they encouraged people to be as independent as possible. One member of staff described how one person liked to help with domestic tasks and we saw this person assisting the laundry person to fold clean clothes. We saw another person who had their top on inside out being encouraged by staff to adjust their clothing and when the person refused, we saw staff respected their choice.

Requires improvement

Is the service responsive?

Our findings

People did not always have access to activities they wanted to participate in. We asked people and a family member about activities offered at the service. The family member said there were always activities when they visited. One person said "Activities? You make me laugh; they expect us to sit [down] all day doing nothing at all." The same person then told us they helped out in the garden growing vegetables. However we did not see any evidence of this in the garden. Another person told us, "I like to paint. That would fill in these lonely hours." On the first inspection day, we did not see any activities being offered and an activities schedule was not available. We spoke with staff about this and they said, "We don't have an activities coordinator, whoever is on shift will usually organise something in the afternoon." On the second inspection day, we did see activities offered which included singing along to music and people were offered newspapers to read.

Staff told us none of the residents attended places of worship but members of a spiritual organisation visited regularly. Staff also told us they supported people to maintain their spirituality by singing spiritual songs with them. However, one person told us they had not been assisted to see a member of their chosen spiritual organisation since they began to use the service.

The service had an activities file and completed daily recordings of the activities completed. These showed that one main activity was offered to all residents and levels of participation varied between 10 and 19 residents. We noted three people consistently did not engage with activities and staff explained these people stayed in their bedrooms. It was recorded that these three people either listened to their radio or watched television. We viewed recorded activities and saw that the activities that were offered included pet therapy visits, movie day, exercises, garden socialisation and sing-along to music. The daily notes kept for each person indicated that activities were not offered regularly and most days involved watching television for several hours. When asked about the people who stayed in their rooms, staff told us that they go up and read poems, books or newspapers with them but this was not recorded in the activities log. We also noted there were no day trip activities or community activities recorded.

We asked people if they thought their individual needs were being met and noted that most people had dementia and did not have the capacity to fully understand what we were asking them. One person said, "I don't like this place at all. We are all individuals and should be treated as such, but we are not, ever." Another person told us the service was okay but that people got better care back in their country of origin. Another person was sitting crying quietly and said, "I am only [age], I don't belong here."

These findings were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's preferences were not always met.

Staff were knowledgeable about how to deliver personalised care. One member of staff told us "The person is paramount, what they want should be upheld." Staff described how they adjusted the support they provided depending on how the person reacted, one staff member said, "If they aren't responding positively, or are getting upset I stop and I ask how do they want to do this."

People's care records were comprehensive, person-centred and pictorial. We saw care records included sections on communication, mobility, spiritual needs and "what I like and enjoy." Person-centred information was included to help plan care that was appropriate and tailored to the individual which included people's preferences. For example, one person was known to become anxious if they spent too much time inside and it was recorded that taking them into the garden and sitting with them for a chat was known to help them relax. We found that people were able to make their own decisions around daily living, such as when and where to eat and whether they wanted to have a shower or bath.

We saw that care plans had been reviewed and updated monthly by the registered manager. There was a system in place for staff to record when a person demonstrated changing or complex behaviour. Where a person's behaviour or personal care needs changed, this was documented and the instructions to staff had been updated. For example, we saw staff had arranged weekly pet therapy sessions to help calm a person's nerves. Some people had photos of their friends and family in their care plan as well as pictures on their bedroom door of things that were important to them, such as the logo of their favourite football team or pictures of their favourite animal.

The home had a complaints policy which gave clear guidance to staff on how to handle complaints. The complaints policy was included in a "service user guide"

Requires improvement

Is the service responsive?

which was displayed in the lounge. Staff demonstrated an understanding about their role in dealing with complaints and told us they would try to resolve them and ensure that the registered manager was aware. A family member told us they had never had to make a complaint but if they had concerns they would, “Tell staff, they take it all into account. They are always ready for feedback.” We reviewed the complaints folder and saw there had been one complaint since the last inspection. The registered manager had given a response within the timescales laid out in the policy. We saw there had been a follow up complaint relating to the same issue two weeks later and although the formal response to this took one month an explanation for the delay was included in line with the policy.

Inadequate

Is the service well-led?

Our findings

We found the service was not consistently well-led. On the first inspection day there were no senior managers available. Staff told us the registered manager and the proprietor were on holiday and the deputy manager was unavailable. This meant there were no senior managers available to attend the service to support staff should an emergency arise. Staff told us they thought the manager was good but under a lot of pressure. Some staff thought the registered manager was not approachable but other staff told us the registered manager was approachable but under a lot of pressure. One staff member said the registered manager was, "Easy to talk to. I can ask [the registered manager] anything."

The registered manager told us satisfaction surveys were carried out with people who lived in the home and their representatives in order to improve the service. We asked to look at these surveys. The registered manager told us they had been stored in the cellar which had been flooded. We asked to see the analysis of the satisfaction surveys. The registered manager told us this had not been done due to the flood. This meant the provider was unable to evaluate the feedback or use it to improve the service.

The provider held meetings twice a year for people. We reviewed the records of the most recent meetings held in November 2014 and May 2015 and saw it was recorded that most people had participated in the meeting. The topics discussed included people being asked what they thought about the food, activities, staffing and choices and the feedback was positive. However we noted in the May meeting, one person had requested outdoor activities. There was no action plan following this meeting to show this request had been responded to.

The registered manager told us they carried out quality audits of the service including random checks on the work carried out by weekend and night staff. We asked to look at these audits. The registered manager told us these were not recorded. We asked if the provider carried out quality audits. The registered manager told us these were also not recorded. This meant the provider had no record of issues identified or an action plan to show how quality would improve.

During the inspection we found concerns around a number of areas. For example, we noted the fire risk assessment and fire evacuation plan were due to be reviewed seven weeks prior to inspection but this had not happened. The registered manager has sent us an updated version of the fire risk assessment and fire evacuation plan since the inspection. We observed an upstairs fire extinguisher needed to be replaced or repaired and two fire doors were propped open. The provider did not have effective systems of assessing and monitoring the quality of the service people received. If there were effective systems in place these issues would have been identified by the provider and measures put in place to ensure they were rectified.

We found record-keeping was disorganised. For example, on the first inspection day, we found paperwork relating to other staff members in one staff members file and paperwork relating to other people's care in one person's care records. This meant that staff could not easily locate important information about people to ensure care was delivered safely.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems to assess, monitor and improve the quality and safety of the services provided. The provider did not have effective systems to mitigate the risks relating to the health, safety and welfare of people using the service. The provider did not act on feedback received from people using the service or their representatives.

Staff told us they would like staff meetings to happen more frequently and they would find it helpful to use these meetings to talk about training and teamwork in more detail. We reviewed the records for the two most recent staff meetings held in February 2015 and July 2015. Topics discussed included timekeeping, use of mobile phones, record-keeping, laundry and team work. The meeting held in February was used to address performance issues in the team, including ensuring work was shared evenly across the team. We noted the meeting in July was used to recognise that improvements had been made.

The registered manager told us there were plans to replace the carpets and redecorate the home including the kitchen and people's bedrooms. We saw that new chairs had been ordered for the lounge area. We asked the registered manager why there was no drying machine for clothes and an iron. The registered manager told us the drying machine had malfunctioned but would be replaced and they would be purchasing an iron.

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 (RA) Regulations 2014 Person-centred care **The registered person did not ensure people who used the service received person-centred care that reflects their personal preference.** Regulation 9 (1) (c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not take proper steps to ensure that care and treatment was provided in a safe way for people using the service.**

The enforcement action we took:
The registered person must assess the risks and do all that is reasonably practicable to mitigate any such risks associated with providing unsafe care or treatment. The registered person must take proper steps to ensure the safe management of medicines. The registered person must take proper steps to assess the risk of, and preventing, detecting and controlling the spread of infections.
Regulation 12 (1), (2)(a), (2)(b), (2)(e), (2) (g) and (2)(h)
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems or processes in place to ensure compliance with good governance.**

The enforcement action we took:
The registered person must have systems to assess, monitor and improve the quality and safety of the service provided in the carrying out of the regulated activity (including the quality of the experience of service users in receiving those services). The registered person must act on feedback from relevant persons and other persons on the services provided on the carrying out of the regulated activity, for the purposes of continually evaluating and improving such services.

Regulation 17 (1), (2)(a) and (2)(f)

We have issued the provider with a warning notice.