Karamaa Limited

The Gables

Inspection report

29-31 Ashurst Road
Walmley
Sutton Coldfield
West Midlands
B76 1JE
Tel: 0121 351 6614
Website:

Date of inspection visit: 11, 12 and 13 March 2015
Date of publication: 30/03/2016

Ratings

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

Overall summary

The inspection took place on 11, 12 and 13 March 2015. Our visit was unannounced on 11 March 2015 and we told the director we would return on 12 March 2015. We returned unannounced on 13 March 2015. The last comprehensive inspection carried was on 31 July and 1 August 2014. We found breaches in the regulations inspected. We commenced enforcement action. A responsive inspection took place on 7 October 2014 following further concerns raised to us. We found that the provider was not meeting the requirements of the regulations inspected and continued enforcement action against the directors of the home.

The home is registered to provide accommodation and personal care for up to 24 people. On the day of our visits we were told there were 19 people living at the home.

Summary of findings

The director registered the home with us in 2011. There has been no registered manager in post since August 2013. However, a number of acting managers have been in post. The owner director of the home told us that they now intended to manage the home on a day to day basis.

Although people told us that they felt safe in this home, there were risks to people that had not been identified and actions had not been put into place to reduce the risk of harm or injury to people. This impacted on the safety of people at the home. During our visit we saw one person was not given soft textured food which we saw their hospital discharge information stated they required. During our inspection visit, the person choked on sandwiches given to them by staff.

Some people told us that they believed they received their medicines as prescribed but other people were not able to tell us about this due to their dementia. We found that suitable arrangements were not in place to ensure that people consistently received their prescribed medicines safely.

Although people told us that staff were caring and kind to them, we saw that staff did not always deliver care to people well. Although staff told us that they received some training, we saw that staff did not always have the skills and knowledge they needed to care and support people safely and effectively.

People and their relatives told us they knew how to make a complaint. Some people and their relatives told us that they felt their complaints were not resolved.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. This meant the quality monitoring processes were not effective as they had not ensured that people received safe care that met their needs.

We found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to risks to people and actions not always put in place to reduce the risk of harm or injury. 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?
The service was not consistently safe.

Risks to people were not always identified and detailed actions not always put in place to reduce the risk of harm or injury.

Suitable arrangements were not in place to ensure that people consistently received their prescribed medicines safely.

Inadequate

Is the service effective?
The service was not consistently effective.

Staff did not always have the skills and knowledge they needed for their job role.

Staff did not consistently understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Staff did not consistently ensure care was delivered in a good way.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People's needs were assessed but planned care was not always reflective of people's needs.

Relatives told us they knew how to raise concerns or complaints if they needed to, but some felt issues raised were not resolved.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

The owner director of the home had systems in place to monitor the quality of the service provided to people but they were not effective.

Where actions were identified as needed to make improvements these were not always implemented in a timely way.

Requires Improvement

The Gables

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.

The inspection took place on 11, 12 and 13 March 2015. Our visit was unannounced on 11 March 2015 and we told the director we would return on 12 March 2015. We returned unannounced on 13 March 2015. On day one, the inspection team consisted of one inspector and a pharmacist inspector. On day two, the inspection team consisted of two inspectors and on day three, one inspector returned.

We had received information of concern about the home and brought forward our planned inspection date. We also reviewed other information we had received since our last inspection.

During our inspection we spoke with and / or spent time with all of the people that lived there. We spoke with 13 relatives, staff on shift and two visiting professionals. We also spoke with the deputy manager and the directors of Karamaa Limited who own and manage the home. We observed how people were cared for by using a Short Observational framework for inspection (SOFI) in the communal lounge area. SOFI is a way of observing people's care to help us understand the experience of people who live there. We also carried out general observations throughout the day. We looked at five people's records and eight people's medicine records. We also looked at information about staffing, feedback and audits of the home.

Inadequate

Is the service safe?

Our findings

We spoke with staff about how risks to individuals were managed so that people were protected from the risk of harm or injury. Staff told us that they felt they got to know people as they supported them. One staff member told us, "We can all look at people's care plan folder but generally we just get to know people after a while."

We looked at five sets of care records. We found that risks to one person had not been assessed and plans were not in place to manage them. We saw that this person's hospital discharge information identified that they were at risk of choking and required soft textured food. We found that there was no risk assessment in place to tell staff what action to take to reduce this risk. We discussed this with staff on duty. One staff member told us, "I think [Person's Name] are meant to have a soft diet. I'm not sure really of the details." We asked the care staff member working in the kitchen to cover the kitchen staff member's absence, if they had any information about people's dietary needs. They told us, "All the food at this home is soft anyway so we don't have to do anything different. There is a kitchen folder about people's likes, dislikes and any needs." The staff member gave us an example of 'fish fingers' being 'soft food' that people were given. They showed us the kitchen folder on day one of our visit and we found there was no information about this person's soft food dietary requirement. This information was located by the deputy manager on day two of our visit but we found it lacked detail.

The deputy manager had informed us that this person 'had choked a few days ago.' We observed that the person was not always offered soft food during our visit. For example on day one of our visit, we saw one staff member give the person a plate of tuna and cucumber sandwiches. On day two of our visit we saw that the person had choked on sandwiches and required the attention of the emergency services.

We discussed our concern with the director of the home about the lack of information available to staff and they told us, "We have 28 days to write people's risk assessments and care plans." The director's business consultant was present during our conversation and told them that they had, "24 hours from admission to the home." The director said, "I was not aware of that."

Care records showed us and the deputy manager confirmed to us that, "[Person's Name] has fallen three or four times since moving here recently." We found that there was no falls risk assessment in place which meant that information was not available to staff to tell them about actions to take to reduce the risk of harm. Staff confirmed to us that they were still getting to know the person so did not have the knowledge of how to manage the risk.

This meant that risks to people were not managed. Actions were not always put in place to reduce the risk of harm or injury. **This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**

People told us that they felt safe living at the home. One person told us, "I feel safe enough living here." One relative told us, "I feel my family member is safe there because none of the people living there are violent."

Staff told us they understood their responsibilities to keep people safe and protect them from the risks of avoidable harm and abuse. Most staff were able to tell us what was meant by abuse and that they had received training from the provider or in previous employment. One staff member told us, "If I thought someone was being abused, I'd tell the provider or shift leader straight away."

During our visit we observed an incident of poor moving and handling practice where a person was lifted. In lifting a person under their arms staff were not protecting the person from avoidable harm. We observed the deputy manager did not address the poor practice. We discussed this with them and they confirmed to us that they had observed the poor practice. They told us, "The staff did not follow the person's risk assessment about how to help them transfer." This showed us that while staff told us they understood their responsibilities in keeping people safe, they did not always follow this through with their practice and poor practices were not corrected when needed.

Most staff told us that they knew how to whistle-blow to the Local Authority or Care Quality Commission if they thought their concerns were not being listened to. Since our last inspection, we have received whistle-blowing concerns about people's care needs not been met and these are been investigated by the Local Authority.

Most staff told us that they had been trained to deal with emergencies. However, a few staff members told us they felt unclear about consent issues for first aid and had

Is the service safe?

concerns that they might be wrong if they caused a bruise to a person during first aid treatment. We informed the director about staff concerns and they told us that they would clarify with staff that they were acting in an emergency situation in a person's best interests. We asked staff about first aid scenarios that might occur from time to time. Most staff were able to tell us the safe first aid action in the event of a fall or a person choking. Staff said they would phone 999 for further assistance. Staff told us that they knew when they needed to complete accident / incident reports. However, we saw entries in care logs or handover forms of falls and choking and found that accident / incident reports had not been completed as required by staff. The deputy manager agreed that the lack of this information had sometimes meant that actions were not taken to reduce the risk of further injury.

One person told us, "Most of the time, I think there are enough staff." People and their relatives told us that overall they felt that numbers of staff on shift had improved. Staff told us that they felt staffing levels had improved. One staff member told us, "Things are much better now on the day shift. We now have enough staff to support people." Another staff member told us, "On the night shift we manage with two staff at the moment." On days one and three of our visit, we were told that the cook was not available for work and a care staff member was covering the kitchen cooking duties. The deputy manager explained to us, "We have telephoned another carer and they are on their way to cover the shift." We saw that they arrived and that this action meant there were sufficient staff on shift to meet people's needs. We discussed staffing levels with the provider. They told us that staffing was determined by people's needs and would be adjusted if needed to ensure sufficient staff allocation to each shift.

Recently employed staff members told us that they were aware that pre-employment checks would be completed on them by the provider. One staff member told us, "I gave details about references when I had my interview." We looked at four records for staff who had been appointed since our last inspection. We saw that the provider's application form lacked detail and meant that applicant's employment history and / or gaps in employment was not requested for by the provider. We discussed this with the director of the home and they agreed a more detailed application form would ensure all relevant information was asked for.

We found that some pre-employment checks such as references had been undertaken by the director of the home. However, we saw that the four staff records did not have Disclosure and Barring Scheme (DBS) checks that had been undertaken by the director. We discussed this with them and they told us, "For three of the new staff we have accepted their DBS check from their previous employer. For one staff member, they have not had any previous DBS and we are waiting for their DBS to come back that we applied for." We asked to look at risk assessments for the staff members to ensure that the director had given consideration in starting staff either without a DBS check or with a DBS check that was, for example, undertaken11 months ago. The director could only locate one staff member's risk assessment during our visit. The lack of a detailed application form and lack of detailed pre-employment checks showed us that the director's recruitment system was not robust.

Medicines were not being stored at the right temperature so they would be effective. For example, the medicine refrigerator temperature records showed that the refrigerator temperature had been above eight degrees Celsius since the 7 January 2015 but no action had been taken to ensure the safety of the medicines being stored in there.

We found that guidance procedures for staff for the administration of 'when required' medicines was not available and therefore the director of the home was not able to ensure that the medicines were given in a timely and consistent way by the care staff.

We observed some poor administration practices taking place during the lunchtime medicines administration round. For example, we saw that one person was asked to take their antibiotic medicine with their lunch. We saw that this particular antibiotic needed to be taken one hour before or two hours after meals. We intervened and prevented the antibiotic from being administered on this occasion. We found that another person had been administered their second dose of an analgesic two and a half hour after their first dose. With this analgesic the minimum time between doses should have been four hours. We found the service did not have a system in place to ensure that specified dose intervals were adhered to. We also observed a staff member displaying poor inhaler

Inadequate

Is the service safe?

administration techniques which would have resulted in the person not receiving their required dose. We intervened and showed the staff member the correct way to administer the inhaled medicine.

We were told that all of the members of staff who administered medicines had received training in the safe handling of medicines from their local pharmacy and had been assessed as competent to administer medicines safely by an external consultant. However, from our observations and talking with staff members that administered people's medicines, the training and competency process had not been effective in ensuring medicines were administered safely.

We looked in detail at eight medicine administration records and found that most people received their medicines as prescribed by their doctor. Although, we did find one person had not received their analgesic cream for eight days because staff had failed to obtain a new supply.

Requires Improvement

Is the service effective?

Our findings

Overall, people and most relatives told us that they felt staff had the skills they needed for their job role. One relative told us, "I feel that my family member is well looked after."

Some relatives told us that they were concerned about the 'high turnover of staff at the home.' One relative told us, "The staff turnover impacts upon my family member. They just get to know staff and staff know how to meet their needs but then they leave." Another relative told us, "I would like to see greater continuity of staff so that they know my family member and how to effectively meet their needs."

We spoke with some new staff members and asked them about their induction and training. All of them told us that they had an induction. One staff member told us, "The induction consisted of being shown around the building and told key information like fire exits but I did not do any training as part of the induction." Another staff member told us, "I worked alongside an experienced staff member on shift when I started my employment. I haven't done any training here yet." One staff member explained to us that the director of the home had accepted their training from a previous employer. We discussed this with the director and asked if they had assessed the effectiveness of previous training and they told us that they had not. Training records showed us that the director had accepted training that had, for example, been completed four years ago. During our visit we observed incidents involving, for example, moving and handling and administering medication which demonstrated to us that staff did not always have the skills or knowledge they needed to carry out their roles safely and effectively.

Staff told us that they felt improvement had been made and overall now felt more supported in their job. One staff member told us, "We've had a staff meeting and the manager [Director of the home] told us what they planned to improve and what we needed to do." Another staff member told us, "The manager [Director of the home] is approachable." The director showed us their staff one to one supervision plan. They told us, "We've just started supervisions for staff and have the plan in place now for these to take place."

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty to keep them safe.

Staff told us that the front door was kept locked for security and people's safety. One staff member told us, "We couldn't really let people go out on their own as they might be unsafe. We'd offer to go with them if they wanted to go out." Staff told us and we saw that they explained to people what was happening and asked people if they would like help with personal care, for example. This showed us that staff acted in accordance with legislation on a day to day basis when undertaking tasks and gaining people's consent and / or explaining to them what was happening.

The deputy manager was able to tell us about the requirements of the MCA and DoLS. They told us, "If the provider was not here, I would make an urgent DoLS referral if a person was asking to leave the home and I believed they lacked mental capacity and it would be unsafe for them to leave alone." Care staff told us that they needed to complete an online training session on the MCA and DoLS. One staff member told us, "It's new to me. I think it's about choices." Another staff member told us, "I've not heard of that." Although training records showed us that most staff had completed MCA and DoLS we found that the training records did not always reflect what staff told us.

The director of the home told us that they had submitted a DoLS application to the Local Authority for all 19 people that lived at the home. We discussed this with them and asked them if this was because they believed all 19 people lacked mental capacity. They told us, "We were advised by the Local Authority to submit applications for everyone in case they were needed. They will carry out mental capacity assessments if needed." Although this showed us that the director was aware of the MCA and DoLS, by submitting a referral for all 19 people it showed they lacked an understanding of the requirements of the law.

Most people told us that they did not have a choice at mealtimes. One person told us, "We don't have a choice and don't know what it is until it arrives but it is usually good." We saw that there was no menu board to remind people about the day's meal choices. However, staff told us and we observed that people were asked in advance of mealtimes what choice they would like. One person told us, "The food is hot and tasty. I like it."

Requires Improvement

Is the service effective?

One relative told us, “My family member needs support and continual prompting to eat and drink. I feel concerned when the staff leave food or drink with them as my family member won’t help themselves.” We observed one person was given their breakfast and this was left with them for ten minutes but no support was offered. A different member of staff later encouraged this person to eat their breakfast. A few relatives told us that they felt staff were not always present in the dining room at mealtimes to offer support to people.

We saw that people were offered drinks, by staff, at set times throughout the day to meet their hydration needs. However, we saw that people did not have drinks accessible to them. One relative told us, “There are jugs of juice on side in the lounge but my family member could not get these themselves or ask for it.” We asked staff about this. One staff member told us, “We do use the jugs of juice at mealtimes for people. If anyone asked for a drink we would give them some.” Although jugs of juice were in the lounge we saw that no one asked for any or helped themselves. One person told us, “The staff are in charge of of those (jugs of juice).” Accessible drinks and frequent prompting of drinks in addition to the set tea trolley times would reduce the risks of dehydration and urine infections.

A few relatives told us that they felt their family member was not always supported to access healthcare services in a timely way. One relative told us, “We feel that the staff do not always notice when my family member needs the doctor. We’ve had to prompt staff to arrange this for them. The result has been that they have needed treatment.” One person’s care record showed us that they were waiting to have their ears syringed but we saw no details about when their appointment was. We discussed this with the deputy manager and they told us, “I did chase it up this week, but forgot to record it. The community nurse was meant to be coming today but they cancelled the visit, so I will chase it up again.” The deputy manager showed us the communication diary and explained any action needed or healthcare appointments for people were usually logged there. We saw various appointments such as GP and dental appointments were recorded. One person’s care record showed that they would benefit from an assessment by Speech and Language Therapy services but we saw they had not been referred. We discussed this with the director and they told us they would submit a referral following our visit.

Requires Improvement

Is the service caring?

Our findings

People told us that they were happy overall with their care at the home. They told us that staff were kind to them. One person told us, "I like the staff. They are kind to me." Another person said, "I'm happy here. I'm looked after." Relatives told us that they felt there had been changes to the staff team for the better. One relative told us, "There has been a lot of change. Staff are much nicer now. More caring now."

One staff member told us, "We've got a good staff team here that are caring toward people." One staff member told us, "I feel that the staff are caring. I would be happy for my family member to live here." Our observations of staff interactions with people showed us that staff cared about the people they supported. We saw staff showed people kindness and treated people as individuals. For example, we saw staff did not rush people when support was being given.

Some people told us that overall they felt they were involved in their care and making decisions. One person told us, "I can decide when to get up or go to bed." Another person told us, "I leave things to my family. I'm happy with that. I feel I am looked after okay."

Staff spoken with told us that they respected people's privacy by ensuring they knocked on bedroom doors and spoke to people when entering. One staff member told us, "When I am helping a person with personal care, I always make sure the bathroom or bedroom door is closed." During our visit we observed staff knock on people's bedroom doors and speak to the person to make them aware of their presence.

Overall, we saw that people's dignity was maintained. Staff spoke with people using their preferred name and were polite to them. We did observe that while people were offered small paper serviette at mealtimes, people were not offered an apron or more substantial napkin. We saw some people may have benefitted from being offered such to maintain their dignity and avoid food spillages on their clothing.

Most relatives told us that they were aware of 'resident and relative' meetings. One relative told us, "The meetings have recently started and it is a good idea." Another relative told us, "There has been improvement and meetings have started. It keeps people more informed about things and changes at the home. I feel I could put forward ideas about the home at such meetings." We saw a notice board had been introduced to share general information with relatives about, for example, meeting dates.

All of the relatives spoken with told us that they could visit the home whenever they wished to. One person told us, "I go at different times and it is okay for me to do that." Staff told us that there were no restrictions on relatives or friends visiting people.

Requires Improvement

Is the service responsive?

Our findings

Some relatives spoken with told us that they were asked about their family member's care and support needs. We saw that this information contributed to people's plans of care. We saw that people's likes and dislikes were recorded. For example, food preferences and how hobbies that they enjoyed. We saw that people and their relatives had the opportunity to give information 'About Me' so that care plans could be personalised. We saw that information about families, previous occupations and hobbies could be shared.

Staff told us that a few people preferred to spend time in their bedrooms rather than in the communal lounge. One staff member told us, "[Person's Name] prefers to spend all their time in their bedroom. We pop in to make sure they are okay but we respect that they wish to be in their own room rather than with others."

We saw that the day time care staff were all female. We asked men that lived at the home if they had been asked if they had any preference about either a male or female carer supporting them with personal care tasks. They told us they could not recall being asked. One person told us, "I don't think I was asked but I don't mind really." We discussed this with the provider and they told us, "It is not something that we have asked people about but we could do."

Overall we found that most people's needs were assessed and a plan of care developed. It was not always evident whether people had been involved in this and people we spoke with were not able to recall whether or ot they had been involved in their care and making decisions about their care plan. While care records showed people's needs were reviewed we found that the reviews were not always effective. For example, we saw one person's care record direct staff to monitor their sugar level in their blood. We discussed this with the deputy manager. They looked for the record but could not locate it. The deputy manager then told us, "The person's needs have changed. We don't actually do that. We thought we might have to but actually never did. The information in the care plan needs reviewing."

On day one of our visit, we observed one person was wearing knee-length elasticated stockings that we saw were too tight and were cutting into their legs. We raised this with staff but saw that they took no action. On day three of our visit we saw that this person was still wearing stockings that were too tight which showed us that staff had not responded to their needs in a timely way.

Overall people told us that improvements had been made to activities offered to them. One person told us, "There's a few things we can do. I don't want to do a lot so there is enough for me." Most relatives told us that they felt activities had improved but further improvement could be made. One relative told us, "The entertainment has improved." Another relative told us, "Some time ago, the owners of the home spoke about mini bus outings and different activities but it hasn't happened. I'd like to see my family member able to go out in the garden and just generally out more." Another relative told us, "The activities staff member is good and do their best with the time they have. But, I feel that more stimulation is needed. I feel that the care staff don't have time to offer entertainment or interaction due to other tasks they have to do." One person told us, "I'd like to go to town but none of the staff have time to take me. I'd like to have a look around the shops."

One staff member told us, "I've recently started as the activities staff member. I've never done this role before but I'm due to start a training course which will be useful. People enjoy the gentle balloon and ball throwing game we do." We observed people participate in this. One person told us, "It's a bit of fun."

We observed that improvement had been made and home group activities were now planned for and took place. However, we saw there were periods of time when people did not have things to do. We saw that the television was on but there was no sound. The seating arrangement meant that some people could not see the screen and most people could not see to read the small writing on the screen. One person told us, "I can't see that from here." We observed one person suffering from dementia appeared anxious at times and did not have any safe meaningful object to handle.

A few relatives told us that they had concerns about communal areas not always being staffed. One relative told us, "In the evenings, there are often no staff in the lounge area. We've had to get staff for people on occasions." During our visit, we saw that the communal areas did not always have staff present. We asked people how they would gain staff attention if needed. One person told us, "Either shout or we'd have to wait for them to come

Requires Improvement

Is the service responsive?

downstairs." We saw that there was no call bell for people to use if they needed to summon staff to assist them. We discussed this with the provider. They told us, "Staff should ask me to come out of the office into the lounge if needed." During our visit we did not observe that this happened, for example during one mealtime when staff were not always in the communal area.

Some relatives that we spoke with told us that they had been asked for feedback on the service provided but others told us they had not been asked. One relative told us, "I have recently received a feedback survey to complete." Another relative told us, "My family member has been at the home for several years. I have not been asked to complete a feedback survey." This showed us that relatives had inconsistent experiences of being asked for feedback. People that we spoke with could not recall completing feedback surveys but we saw opportunities were given to them in the form of accessible 'smiley' face surveys which showed us that people that lived there had the opportunity to give their views about the service provided.

Most relatives told us that they knew how to make a complaint. Relatives told us that they felt they could raise most issues they had with the provider if they needed to. One relative told us, "I complained about an issue and it has now been resolved." However, a few felt concerns had been rasied but not always resolved. We were unable to look at whether learning had taken place from concerns or complaints raised to improve the quality of the service because there was no record of any. The provider told us, "We've had no complaints since the last inspection. We had a couple of issues about the laundry service but we've introduced a new system so that has improved now."

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection, the acting manager had left their employment. There was no registered manager in post. One staff member told us, "The owners are now here much more. One is now the manager and is here most days during the week. They are approachable." The director told us that they had decided to take on the day to day management of the home.

Staff told us that they felt they worked well as a team. One staff member told us, "There has been a great deal of improvement to the staff team and we work more as a team now." The deputy manager told us, "I try to act as a role model to staff. I try to make sure there is a positive culture within the staff team." All of the staff told us they felt well supported by the deputy manager. Overall, staff told us that they felt it was positive that the home owner was taking on the day to day management.

One staff member told us, "We have training now. It is much better. The provider is arranging more for us to do which will help us in our jobs." Some staff told us that they were completing a vocational diploma in health and social care with a local training provider. This showed us that systems were in place to provide developmental opportunities for staff.

Prior to our inspection, the provider had told us that the required improvements had been made. However, during our visit the provider told us that they now felt that some of their care record paperwork and systems of audit could be improved upon. The provider told us, "In January 2015 we had a 'compliance audit' completed for us by a consultancy firm. We also have another business consultant planned for this week. We hope to work with them to make further improvement and implement more efficient systems to audit the service for example and put better care plan paperwork in place."

We looked at the 'compliance audit' from January 2015. We saw that action points had been identified to the provider by the person asked to undertake the audit. However, we found that there was no action plan to implement the points identified in the audit and we found that actions had still not been taken. We discussed this with the provider and they told us that was their aim for March 2015 to work with the business consultant and implement improvements that were needed.

We saw that there were systems in place to monitor the quality of the service provided. However, we found that these were not robust. For example, we looked at the February 2015 Infection Prevention Room Check audit. We saw that there was no detail about what was being checked as part of the audit.

The provider told us that spot checks were completed on staff but these were mostly informal. They explained to us that they were implementing a 'dignity and respect' observation tool to formalise staff spot checks. We saw that this was a 'tick list' of relevant points in maintaining people's dignity and respect. However, we saw that where actions to improve had been noted, no further action had been taken.

We saw that there were quality assurance systems in place to monitor the quality of the service provided to people. We looked at completed feedback surveys and saw that there was a statistical analysis of results but no action plan to make improvements. We discussed this with the director. They told us, "We'd compare the feedback forms to see if things were better." This meant that there was not always a timely response in assessing whether people felt improvement in the service provided had been made.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Risks to people were not managed. Actions were not always put in place to reduce the risk of harm or injury.

The enforcement action we took:
We continued with enforcement action commenced.