Durham Careline Limited

Nevilles Court

Inspection report

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Ratings

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

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 provide a rating for the service under the Care Act 2014.

Nevilles Court provides accommodation and personal care for four people with learning and physical disabilities living in their own apartments on one floor. Each apartment consists of a kitchen, dining area together with a bedroom, a sitting area and a bathroom.

This inspection was unannounced and took place 17, 18 and 21 July 2014. At our last inspection in May 2013 we found the service we found the service to be meeting all the regulatory requirements looked at during the inspection.

The registered manager was also registered in respect of other services owned by the provider and was not based at Neville's Court. 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.

Summary of findings

We found people were not always protected against the risks associated with their diagnosed conditions, although they were safe through the appropriate use of medication. The provider's policy on medication did not include topical medication.

People were supported to undertake a weekly food shop and maintain a balanced diet. However we saw that this was not always put into place by staff.

People who used the service, their relatives and staff all told us there were sufficient staff at the service. We found staff were used to task based practice when supporting people who required additional support. For example staff were aware

The managers who were present at the time of the inspection and the staff were able to describe to us Deprivation of Liberty Safeguards (DoLS). We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

Staff received training and supervision to assist them in undertaking their role. However we were concerned staff did not always receive training to allow them to perform their role with sufficient competency and skill. For example staff were caring for people with medical conditions about which they had not received any training or given any information.

People were supported to access appropriate health professionals where they experienced a change in their health and well-being.

Care was not always delivered in a way that was responsive to people's individual assessed needs.

People who had not had any reason to complain told us they were aware of how to make a complaint if necessary. We saw in one person's file if they became angry about an issue they were to be given an opportunity to complain.

Quality monitoring processes did not always identify shortfalls in the quality of care planning and risk assessments.

We found 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We saw the recruitment process for staff was robust to make sure staff at Nevilles Court Care Home were safe to work with vulnerable people. We found there were enough staff on duty to meet people's needs.

Staff we spoke with knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005. This is legislation that has been designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. We found the location was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw from the staff training records that staff had a programme of training and were trained to care and support people who used the service safely. However, we found staff had not received training in working with one person's medical condition and were unaware of how to care for that person safely.

We found people led the service, but the service was not run to meet people's assessed needs, as a result the service was not fully effective.

Records showed people had regular access to healthcare professionals, such as GPs, district nurses, community matrons and podiatrists however the service did not follow best practice by ensuring each person had a detailed health action plan in place.

Is the service caring?

Good

The service was caring.

People said staff were kind and caring, treated them with dignity and respected their choices. This was confirmed by our observations, which showed staff displayed warmth and friendliness towards people and regularly checked with them to see if they were in need of any assistance.

Staff were able to tell us in detail people's preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People's health, care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative. However we witnessed staff behaving contrary to the care plans.

We saw people had a weekly planner in place but the activities on the planner were failing to engage people in meaningful and safe activities. People were not connected with the local community and activities undertaken during our visit did not fit with people's expressed wishes or their personal goals.

We saw from the records that complaints were responded to appropriately and people were given information on how to make a complaint. One person told us their complaint had been dealt with to their

Is the service well-led?

Audits were carried out in relation to infection prevention and control, the environment and the medication systems. This helped the registered manager make sure the systems in place to keep people safe were working as they should be. However we found the audits in relation to care planning and risks assessments failed to identify the deficits.

We found the manager worked from a different home and people described the registered manager as being available only if there was a problem.

Requires Improvement

Nevilles Court

Detailed findings

Background to this inspection

The inspection team for this service consisted of two adult social care inspectors. Before our inspection we reviewed all the information we held about the service. We considered the nature of safeguarding alerts that had been made and any other information that had been shared with us. We were not aware of any concerns from the local authorities who commissioned the service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR) This is a form which asks the provider to give some key information about the service, what the service does well and key improvements the service plans to make. We used this information to inform some of our planning. We also reviewed notifications made by the provider.

We inspected the home on the 22 and 23 July 2014. This inspection was unannounced. At the time of our visit there were four people living at the home. We undertook informal observations of care in the communal area and people's apartments. We looked at all areas of the home and spent some time looking at documents and records that related to people's care and the management of the home. We looked at three people's care records.

Over the two days of our inspection we spoke with three people living at the service. We also spoke with two relatives of people who used the service. We spoke with seven staff including the regional manager and the deputy manager. We also spoke with three other professionals who visited the home. The Registered Manager was away from the service on our inspection dates.

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

One person told us about how staff supported them to carry out what they wanted to do and told us, "It is good living here."

We looked at people's care and support needs in the home and found that each of the four people living at Nevilles Court had very different needs. We saw the provider had told people in their 'Welcome and Information Pack, 'We make every effort to provide each person with the care and support they need in line with their assessed requirements, their wishes and feelings. We make sure that everyone is kept safe from harm of any kind by assessing and managing all the risks to maintain people's safety and wellbeing' .

We looked at three people's care files. We saw risk assessments had been completed in relation to moving and handling, nutrition and specific behaviours. These identified potential risks for people and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. We saw that earlier in the year, one person had been injured through the use of inappropriate moving and handling. The provider had changed the person's risk assessment. Staff told us what they had to do to keep that the person safe, the information staff gave to us concurred with the risk assessment. This meant staff had learned about the person's additional needs to keep them safe.

One person had recently been diagnosed with a medical condition which increased the risk of them choking. We saw there was a letter on the person's file dated two months previously from their doctor outlining their condition and the associated risks. We asked the staff what they knew about this condition and what they were expected to do in an emergency. One staff member told us they had asked for a training course and were waiting for a date. Another member of staff told us what they would do if the person started choking including seeking medical attention. We asked the deputy manager what guidance had been given to staff and were told no guidance was available but they would ensure guidance would be made available that day. We expressed our concerns to the regional manager that there was a person living at Neville's Court for whom the staff had been caring without appropriate training or a care plan and risk assessment in place and that this placed the person at risk of harm. The regional manager acknowledged our concerns.

We had received a number of notifications about a person who was threatening to put themselves at risk when they were going out. We looked at their risk assessment and found it did not address the risks. We spoke to their relative who said suggestions had been made to the staff to minimise the risks and they had not been carried out e.g. always ensuring their mobile phone was charged. This meant that the appropriate risks had not been identified and actions to mitigate those risks were not in place. We spoke with the regional manager and deputy manager and expressed our serious concerns regarding the person's safety whilst out of the home. Our concerns were acknowledged and we were informed appropriate risk assessments would be completed.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we returned on day two of our inspection we found the deputy manager had used information from a national organisation and put together a plan for the person to address the risks. The information was in a handover file for staff to read to make sure the person could be kept safe. We also saw this had been done for staff to understand another person's condition in the home as there were similar gaps in their care plan and in staff knowledge.

We found one risk assessment in a person's file which said the person was 'to be shown around the building, particularly the lift to transfer between floors'. There was no lift in Nevilles Court. We asked the deputy manager about this risk assessment and they told us it had been brought from a previous home and it was not relevant to Nevilles Court. We found the person's risk assessments needed updating to match their current environment.

Care staff told us they were responsible for the cleanliness and hygiene in the building. They showed us cleaning checklists of what they had to do. We saw cleaning being carried out by staff and heard one member of staff being accountable to their senior about the cleaning they had undertaken. We found the home to be clean and areas of

Requires Improvement

Is the service safe?

potential infection minimised. When we looked at people's weekly plans we saw they were also responsible with support from staff for cleaning their apartment, time was set aside during the week for their own cleaning.

We looked at the arrangements in place for people's medicines and saw the provider had in place a medication policy. The policy did not include any reference to topical medication for example, creams. However we saw that where people required intermittent use of topical medication a separate medication administration record (MAR) had been set up to monitor its use. This meant that the use and impact of the medication used on people's skin could be monitored. Two people had their medication kept in their own apartment in a locked metal cupboard. We were unable to check the contents as these people did not want to speak with us. We saw the other two people's medication was stored in a locked drugs cabinet. The senior care staff showed us they used the 'bio-dose' system which is a four weekly dosette box. Each box had a photograph of the person imprinted on the side, this aided staff to give the right medication to the right person. We looked at each person's medication MAR and found there were no gaps in people being given their medication. The amount of medication stored for people concurred with the records. We found that the service's medicines arrangements protected people against the risks associated with medicines.

We looked to see if staff were safely recruited and found out of the nine staff records we reviewed all of them had a completed an application form and had provided two referees as well as undergoing a Disclosure and Barring Services (DBS) check. This check allows the provider to make a decision if a staff member is safe to work with vulnerable people. We saw the provider had contacted referees and verified with the author of each reference that they had written the reference. Staff confirmed to us they had undergone this process before they started working with people. This meant people who lived at Nevilles Court were protected because the provider ensured that people employed were suitable to work with vulnerable adults.

Staff were able to tell us about the different types of abuse and told us about the reporting systems in place if they suspected abuse was taking place. One staff member told us they worked as a team to keep people safe.

We checked staff rotas to see if there was sufficient staff on duty. Staff told us there were always two people on duty supported by a deputy manager on site and the registered manager who was on call. We asked the staff if there was enough staff on duty. They told us they planned their time and people wanted different things at different time so they could "fit it all together." The deputy manager also told us they were available to support people as required. At the time of our inspection the registered manager was on holiday and the regional manager was in the home. We found the staff rotas described what the staff had said. In addition we observed a member of staff covering additional hours to provide one person with 1:1 support as required in their care plan. However the person had asked to go out earlier than planned and had a period of unstructured time whilst they paced up and down and waited for another staff member to arrive.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We saw policies and procedures were in place and the deputy manager was able to explain the procedure for submitting an application to the local authority. We found the provider had submitted one application and were waiting for the outcome.

We also looked at how the building and the equipment within it were maintained. We found the service kept clear records of maintenance required and where equipment such as hoists and wheelchairs required servicing these were done in accordance with the manufacturers instructions.

Requires Improvement

Is the service effective?

Our findings

We saw the provider had in place an annual training analysis. The analysis allowed the registered manager to tell the provider what training her staff required in the coming year. Staff told us about their training and told us if they needed additional training this was usually responded to positively. We saw certificates on staff files to indicate they had received a broad range of training including equality and diversity, first aid, moving and handling, medicines administration.

We reviewed staff records and found staff had regular supervision meetings with their manager to raise any concerns and review their progress and performance. We saw in the supervision meetings managers had addressed unacceptable staff behaviour. This meant staff were being support and given guidance on the requirements of the service. We also staff had received an annual appraisal. Staff confirmed to us supervision and appraisals took place.

In the provider's Statement of Purpose we read, 'The service's aim is to support, stabilise and provide a pathway to other "ordinary living" models of care. Bespoke transition programmes will be designed to reflect the specific needs of the individual.'

When we spoke to staff they told us they did whatever people wanted them to do and it was up to the people who lived there to decide on their daily activities. We observed staff carrying out tasks as required by the people who lived there. We also saw people had in place a weekly planner; the planner was broken down into mornings, afternoons and evenings over a seven day period.

We spoke to one person who told us about their weekly planner. We saw mornings between Mondays and Fridays was supposed to be spent either watching TV, reading magazines or listening to music. Other pictures included a time for weekly clothes shopping. Saturday and Sunday mornings had a picture of a mouse lying down. We asked the person what they did on a weekend and they told us "the same as what I do on other day." We asked the deputy manager what the difference was between weekdays and weekends and were not given a response. We found people in the service were not guided by staff according to their interests and to support their development to other 'ordinary living' models of care as described in their statement of purpose.

We asked people what did it mean when there was a picture of woman dusting and the words 'Life Skills'. They told us that was when they were expected to clean their room, but one person told us if they "put their dirty dishes in there (the sink) the staff would tell them to wash them and if they put their dirty dishes on there (on the kitchen surface) the staff washed them." They told us they were 'bored' with cleaning. We found one person was expected to do life skills on a Tuesday afternoon and evening and a Thursday afternoon. We asked the staff why were people expected to do cleaning on an evening, the staff member told us, "They don't." We found that people had developed ways of avoiding doing tasks. This meant that the service structure was not effective in engaging people to develop life skills and people's definition of life skills disengaged them from learning.

In one person's file we saw they needed support to eat a healthy diet. The records showed that when out shopping the person might say they do not eat hot food so they could buy junk foods and this was not allowed to happen. Other records showed that they often slept late. On the morning of our inspection the person got up late morning and at 3pm that afternoon we heard a member of the care staff offer them lunch as they had not eaten. The person declined and the staff member offered them biscuits instead which they agreed to. This meant that the delivery of care to that person was inconsistent with their assessed needs.

We also read in the provider's Statement of Purpose:-

'Our aim is to work closely with our individuals and professionals to actively support participation in activities that encourage social inclusion whilst maintaining the safety of individuals and those around them.

We respect the rights and opinions of individuals by providing appropriate support to enable participation in opportunities that will lead to a fulfilling and meaningful life.'

We found people were not effectively engaged in goal setting, planning and were not supported to participate into the local community in line with the provider's statement of purpose. For example in one person's file we

Requires Improvement

Is the service effective?

saw it was written 'staff to read [person's] activity planner in the blue folder for ideas to encourage [the person] to be more active'. We saw the person's weekly planner and found that they were not engaged in any community activities or were engaged in activities outside of the home. We looked at their recreational care plan and it included 'dusting, cleaning and sorting out the person's wardrobe'. We found that the person's care plan did not reflect their assessed level of need.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We observed one person leaving the building in their socks, they were encouraged by staff back into the house and then tried to leave the building in their slippers. They told us their plan was to go into Newcastle-Upon-Tyne to buy sweets and their slippers "were comfortable." We observed the regional manager try to engage a person in more meaningful activities. On return from their outing we asked the staff member what they had done, the staff member told us the person had taken them all over Newcastle and then all over the Metrocentre. We asked the staff member about the purpose of the day and it was explained to us that it was about what the person wanted to do. The person showed us the amount of sweets they had bought and their blue tongue as a result of eating the sweets. We found that although the outing was person led it did not engage the person in a meaningful activity consistent with their care planning.

We spoke to a family member who told us they were concerned their relative spent considerable time in their room and did not get out as often as they would have liked. Another person told us the service was not managing the behaviours of their relative as they did not have the correct structure and expectations in place. As a result of this they felt their relative was not making progress. This viewpoint was supported by another professional who visits the home.

We looked at three care plans and saw people's preferences in relation to food and drink had been recorded. We saw people had a balanced menu planned for the week People told us they went shopping once each week with a staff member and bought their food for the week with a budget of £40. We saw one person was supported by staff to take the shopping to their apartment. One person showed us the contents of their fridge and told us what meals were available to them . They showed us how to use the cooker but said that they could tell staff they did not know how to use the cooker and staff would cook for them if they wanted them to do that. This meant that the person was not developing the skills required to live independently.

We also found where one person displayed complex behaviours which challenged the service the provider did not have detailed plans in place informing staff of the strategies and interventions to use when managing the person. However we also saw in another file detailed plans were in place for a person who may have displayed inappropriate and challenging behaviour in public. We talked with the acting manager about the use of cognitive stimulation programmes to support people as well as specific training for staff in managing complex needs. We were told that a training source had been identified and was due to commence later in the year.

We found the service emphasised the need for people to make their own decisions and choices and we saw people doing that. However we found the service did not have clear expectations in place about people's behaviour and aspirations. Instead people were left to choose what they wanted to do which was different from their weekly plans and the weekly plans failing to engage people. This meant that although the service was person led it was not person centred and the service was not effectively meeting people's care and welfare needs. We found the service did not engage people in Positive Behaviour Support and people with complex and challenging behaviours did not have relevant support plans in line with the Department of Health Guidance.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Good

Is the service caring?

Our findings

We saw the provider had in place a 'Welcome Pack' entitled Careline Lifestyles with the strap line 'inspiring lives and environments'. The welcome pack told us the provider delivered person centred care. The welcome pack provided easy to read documents about safeguarding and complaints. This meant people who experienced literacy difficulties were able to understand what the provider offered.

One person told us their relative was 'well-cared for' at Neville's Court and when they arrived to visit the staff had been caring towards them by offering them a drink.

We reviewed three people's records which all included information about each person's preferences. Staff were able to tell us about each person's likes and dislikes and their preferred routines for example going to bed and getting up times. They demonstrated an in-depth knowledge and understanding of people's preferences and routines.

We listened to staff talking to people and found they spoke calmly and respectfully to people. One relative told us they thought the staff were 'great'. Another person said they 'liked them'. One person told us their relative was 'very happy' at Nevilles Court and they are always offered a drink on arrival. One person told us the staff were able to meet their needs and they enjoyed living at Nevilles Court, they said, 'I am more independent'.

We saw staff were patient; they approached people with respect and worked in a way that maintained people's dignity. We saw staff knocked on people's apartment doors before entering. We saw that in one plan a person expressed a wish for two gender specific carers. It had been explained to the person that this was not always possible; however special arrangements had been put in place whereby the staff who met the person's gender specific requirements carried out most of the tasks.

When we looked in people's apartments we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff supported people with their belongings. We also saw the rooms had been arranged to meet people's needs, for example one person had been enabled to access a computer.

Staff we spoke with were able to tell us about people's care needs and the support they provided to people. For example following a recent diagnosis a person's dignity was at risk of being compromised. We asked the staff what plans were in place to ensure the person's dignity could be preserved. Staff were able to tell us what they would do to care for that person. We saw people looked well cared for. People were dressed in clean, well-fitting clothes.

We looked at the arrangements in place to support people make difficult decisions where they may not have had anybody to represent them. We saw that one person had a professional advocate whom they contacted or asked the staff to contact them on their behalf. The staff told us the person could contact the advocate themselves or they would contact the advocate on behalf of the person if they asked. We also saw that additional arrangements had been put in place to protect a person's finances which enabled them to be in charge of their personal funds.

Requires Improvement

Is the service responsive?

Our findings

The manager told us an assessment was completed before people moved into the home to make sure staff could meet the person's care needs. In addition where people had a social worker a copy of the multi-disciplinary assessment (an assessment made by a team of health and social care professionals) was also in the care plan and provided staff with additional information about the person. We saw assessment information in the three care files we looked at.

During our inspections we saw staff moved between people's apartments as they called for assistance. No one was kept waiting for attention.

Staff told us about the relatives who visited and how people maintained contact with their families. They were able to explain to us the anxieties some people had about contact with their family members and how this was managed. We saw staff putting this into place when one person became anxious about not being able to contact a family member at a particular point in time.

We looked at the complaints procedure and saw that the definition of a complaint included any expression of dissatisfaction. We asked the staff what constituted a complaint and they said 'anything'. The subject of complaints was an agenda item at a recent staff meeting and staff had been reminded of the policy. We saw in one person's care plan that if they became frustrated they were to be offered an opportunity to make a complaint as a way of them being able to describe why they were frustrated. One person told us they had made a complaint about the noise caused by their neighbour. The person told us they had been satisfied with the outcome. When we read the outcome of the complaint it also said that the person who complained needed to get out and do more activities. We noted the person had their own transport and asked did that help them to get out more. They told us 'no' because the staff on duty were not always able to drive their vehicle. On further questioning the person told us if they wanted to go out this could take up to three days before staff were available to take them out in their vehicle. This meant the service was not able to respond to the person's needs having highlighted the needs following a complaint.

We saw in people's files there were behaviour contracts in place. One person explained to us that they were put on a contract if they misbehaved. A relative told us they didn't like contracts and 'there should be no need for contracts' with people with disabilities. On further discussion with the relative they felt if the service was structured to provide the right kind of activities instead of letting people do exactly as they wanted from day to day then there would be no need for contracts

We saw one contract involved the person wearing protective head equipment. The contract secured the person to wear the head equipment at all times, however the person then asked the staff if they could have the equipment removed so they could comfortably eat their meals. We found the use of a contract to manage a person's well being had been insufficiently personalised to meet their needs.

People were able to tell us about their medical and dental appointments and which member of staff was supporting them to get there. Staff were also able to give us the same matching detail. This meant staff had responded to people 's individual needs and people were reassured they would get the medical and dental attention they needed.

One relative expressed concern that their loved one may due to their condition be unable to continue to live at the home. They told us they had been assured by staff that all would be done to enable that to happen. The staff echoed the same statement to us. This meant the service was aiming to ensure continuity of care for someone who lived at Nevilles Court.

One person told us they had some work experience but were unable to attend due to their behaviour. We asked what else had been tried to support them and they said, 'nothing'. They told us about starting a college course in September.

During our inspection one person wanted to change their activities and go out for the day. We saw a member of staff came in early to facilitate the person's wishes.

Requires Improvement

Is the service well-led?

Our findings

During this inspection we found the quality assurance system had failed to identify and rectify poor practices relating to care planning, risk assessment and staff training needs. This meant people's needs and changing needs were not measured, reviewed and appropriate action taken.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We expressed our concerns to the regional manager regarding a lack of leadership which meant potentially unqualified and unskilled staff, although they were caring, were left to identify when they required expert help. This meant people were often receiving care which was not in line with best practice but also not effective or safe.

We saw the service had in place a periodic service review. The review looked at areas of health and safety and infection control. It included an action plan. We saw the manager had listed actions and identified responsible people to action them within agreed timescales. We saw the actions had been completed. The senior carer on duty told us they had been competency assessed by the deputy manager to carry out the audit. This was confirmed by the deputy manager. This meant that a culture of continuous improvement was shared amongst all staff in a management role.

Following a recent inspection at another home owned by the provider a decision was taken to implement practice development meetings. We saw Nevilles Court had held its first practice development meeting where people's behaviour and support solutions were discussed as well as solutions. Another practice development meeting had been planned. This meant the service had begun to involve staff in developing good practice.

We saw that the service had undertaken an analysis of the feedback it had received during recent surveys. The survey results were largely positive. The regional manager told us that it was difficult to repeatedly ask people for a satisfaction rating due to the small number of people who used the service and they were developing plans to ask alternative and more specific questions in the future. People who used the service and their relatives told us they had been asked about their experiences of the service.

We saw there were systems in place to maintain, for example, the gas safety certificate, electrical wiring, hot water temperatures, legionella checks and testing of small electrical appliances. This meant the building and its contents were under review to ensure the premises were safe for people.

Accidents and incident reports were recorded and securely stored in the office and audited by the manager. This meant any trends would be identified and appropriate action would be taken to reduce any risks to people who lived in the home.

People told us they rarely saw the manager. Staff told us the manager worked from another home and they had been told to contact her whenever she was needed. Staff also told us the manager passed the home each day on her way to work and had said she was available to call in whenever needed. We found that the management system in place was one of reactive management rather than proactive, which meant that the manager was perceived to be available only if there was a problem.

We also saw managers had discussed with staff behavioural expectations in supervision meetings. The provider's supervision policy stated that these meetings with each member of staff were to take place a minimum of 6 each year, the records showed people were receiving regular supervision. Staff confirmed that the meetings took place. Staff were also aware of the whistle blowing procedures should they wish to raise any concerns.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken appropriate steps to ensure that each service user was protected against the risk of inappropriate or unsafe care.**

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 suitable arrangements in place to monitor the quality of the service provided which protected people from inappropriate or unsafe care.**