# Caring Homes Healthcare Group Limited

# Garth House

## Inspection report

Tower Hill Road, Dorking,
Surrey. RH4 2AY
Tel: 08082235507
Website: www.caringhomes.org

Date of inspection visit: 06 August 2015
Date of publication: 09/11/2015

## Ratings

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

## Overall summary

Garth House provides accommodation and nursing care for up to 42 older people, some of whom were living with dementia. At the time of our visit 36 people lived here.

The home is a converted domestic detached property and care is provided over three floors. Stairs and a passenger lift provide access to all floors. Communal space consists of lounges, a dining room, a conservatory and large mature very well maintained landscaped gardens to the side and rear of the property.

The inspection took place on 6 August 2015 and was unannounced. At our previous inspection in August 2013 we had identified one concern at the home. This was regarding the safety and suitability of the premises. These concerns had been addressed by the registered manager when we checked during this visit.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

Overall there was positive feedback about the home and caring nature of staff from people and their relatives. One

# Summary of findings

person said, “Staff are extremely good; without their care I would be lost; They’d do anything for me.” However there were three areas of concern we identified – deployment of staff; Where best interest decisions had been made for people this had not followed the requirements of the Mental Capacity Act; and lack of meaningful activities that interested people.

The lack of staff to meet the identified needs of individuals had an impact across three of the key questions that we looked at. It impacted on the safety of people as staff were not always available to give support that had been identified; It affected the caring ability of the staff as they had little time to spend with people to talk with them, as they were very task focused to try to do everything at once; It reduced the responsiveness of the service so that activities were not based around individual’s interests.

When people did not have the capacity to understand or consent to a decision the provider had not followed the requirements of the Mental Capacity Act 2005. Where decisions had been made for people an appropriate assessment and review had not been completed. People told us that staff did ask their permission before they provided care.

Where people’s liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards to ensure the person’s rights were protected.

People did not always have access to activities that met their needs. The home had a dedicated activities person, however much of their time was taken up with assisting with care needs due to lack of care staff. Activities were not always based around the individual interests of people, and activities for people living with the experience of dementia, such as one to one time with staff did not happen on the day of our inspection.

The staff were generally kind and caring and treated people with dignity and respect; However we did identify some actions by staff that could have been more caring, such as interactions when supporting people to eat, and when giving medicines.

People were not always safe at Garth House. Risks to people’s health and safety had been identified and guidelines to minimise the risk were in place.

Staff had a good knowledge of their responsibilities for keeping people safe from abuse. The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home. Staff received training to support the individual needs of people in a safe way.

People received their medicines when they needed them. Staff managed the medicines in a safe way and were trained in the safe administration of medicines.

People told us that they enjoyed the food and had enough to eat and drink. They were involved in the food choices on the menu and had a choice of what to eat. People on specialists diets, either medical or due to religious or cultural beliefs had these needs met.

People were supported to maintain good health and they had access to relevant healthcare professionals when they needed them.

Care plans gave a good level of detail for staff to reference if they needed to know what support a person required. People and relatives told us that they had been included in the development of the care plans, and in reviews.

People knew how to make a complaint. Feedback from people was that the registered manager and staff would do their best to put things right if they ever needed to complain.

People and staff had the opportunity to be involved in how the home was managed. Meetings were held with them, and surveys were sent out asking for feedback about how well the service was doing. The registered manager used the feedback to improve the service.

Quality assurance checks were regularly undertaken by the provider and the registered manager to monitor health and safety, medicines, and quality of care provided and to identify areas for improvement. This was to ensure people received a good quality service.

We identified two breaches of the regulations. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Requires improvement**

The service was not always safe.

There were not always enough staff to meet the needs of the people. People and relatives told us staffing was an issue. People had to wait to receive support and staff were not present to support peoples identified needs.

The provider had identified risks to people's health and safety and put guidelines for staff in place to minimise the risk.

People felt safe living at the home. Staff understood their responsibilities around protecting people from harm.

Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

**Is the service effective?**

**Requires improvement**

The service was not always effective

People's rights under the Mental Capacity Act were not met. Assessments of people's capacity to understand important decisions had not been recorded in line with the Act.

Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified.

Staff had access to training to enable them to support the people that live here.

**Is the service caring?**

**Requires improvement**

The service was not always caring.

People told us the staff were caring, friendly and respected them; however we identified areas where staffs actions were not as caring as they should be.

The home's decoration and facilities in bedrooms were not always appropriate to meet the needs of people living with the experience of dementia. One area of the home had a strong odour due to the facilities not meeting the behavioural needs of an individual.

Staff involved people in how their day to day care was given.

# Summary of findings

**Is the service responsive?**

**Requires improvement** 

The service was not always responsive to the needs of individuals.

People had access to activities; however these were not always personalised or effective at meeting the interests and need of the people.

Care plans were person centred and gave detail about the support needs of people. People said they had been involved in their care plans and reviews.

People knew how to make a complaint. They said the registered manager and staff would do all that they could to address any concerns they raised. There was a clear complaints procedure in place.

**Is the service well-led?**

**Good** 

The service was well led.

People were very complimentary about the friendliness of the staff.

The registered manager carried out checks to make sure people received a good quality service.

People and staff were involved in improving the service.

# Garth House

**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 took place on 6 August 2015 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone, who uses this type of care service. Our expert had personal experience of caring for someone who lived in a care home environment.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 10 people, five relatives, and seven staff which included the registered manager. We observed how staff cared for people, and worked together. We used the Short Observational Framework (SOFI) to understand the experiences of people we were unable to verbally communicate with. We also reviewed care and other records within the home. These included seven care plans and associated records, seven medicine administration records, four staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in August 2013 we had identified a concern in one area at the home. This was around the safety and suitability of the home. At this visit improvements had been made with regards to this.

Requires improvement

# Is the service safe?

## Our findings

People told us that they felt safe living at Garth House. One person told us, "I feel safe; I'm not worried about anything because they look after me." However we identified a concern around the numbers of staff deployed at the home.

There were not enough staff deployed throughout the home to meet the needs of people. People told us there were not enough staff. One person said, "They are short of staff but utilise who they have." A third person said that, "I like to get out of bed, but sometimes I have to stay in bed when I want to get up, as there are no staff around." Another person said, "I should be turned every 2-3 hours, but I am not getting this." During our observation there where periods of time where staff were absent in communal areas. People asked for assistance but no staff were available to help them. For example a nurse called on care staff to arrange for two people sitting in wheelchairs to be moved into armchairs for their comfort. This was not done until 15 minutes later. When staff did enter rooms this would tend to be because there was a task that needed to be completed. By talking with people, making observations and looking at staffing rotas, we could see that staff deployment was not sufficient to meet the needs identified for the people who lived there.

Areas of the home were left without staff throughout the day. A number of people who stayed in bed lived on the second floor. At a number of occasions throughout the day no staff were present on this floor, which went against the providers staffing rota. This meant there would be a delay in people getting help as staff were not deployed where they should have been.

An activities worker was employed at the home, however during our inspection much of their time was spent carrying out care based tasks, such as getting drinks for people, as care staff were not available to do this.

Staffing had been adjusted to include senior carers, which gave an increase in staff quality. Some shifts had changed to be more effective. For example increased staffing in the morning so choice could be provided regarding people's morning care. However these changes were not yet meeting the needs of people. There had been a very high turnover of staff within the last 12 months. People told us they often did not know the carers who looked after them.

As there were not enough staff deployed at all times to meet the needs of people this was a **breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People were kept safe because assessments of the potential risks of injury to people had been completed. risks to people had been identified and clear plans were in place to support people. These assessments looked at risks from the environment as well as from people's personal support needs. Assessments had been carried out in areas such as risk of falls, nutrition and hydration and pressure sores. Measures had been put in place to reduce these risks, such as pressure relieving equipment for people at risk of developing pressure sores. Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs.

The management of risk around the home did not affect people's choice. People told us there were no restrictions around the home, and they could go into the garden when they wanted. Systems such as a wireless nurse call system also enhanced the safety of people. These could be carried around by the person so they could call for assistance from anywhere in the home. Call bells were seen to be in place within reach of people throughout our inspection.

People were kept safe because staff understood their responsibilities in relation to safeguarding people from abuse. People told us they could talk to staff if they had concerns for their safety. One person said, "If I was unhappy about anything or felt afraid I would shout for help, and I know staff would come." Staff had undertaken adult safeguarding training within the last year. Information about abuse was available to staff via posters in the staff rest area. These explained about abuse, what it is and who it needed to be reported to. There was also information about Duty of Candour on display to encourage openness and transparency, with a duty of staff to report and act if they saw something. Staff were all able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy.

The home's design and maintenance reduced the risk of harm to people. Flooring was in good condition to reduce the risk of trips and falls. Equipment used to support people was regularly checked to make sure it was safe to use. Items such as hoists and fire safety equipment were

Requires improvement

# Is the service safe?

regularly checked. A nurse call system was in use so that people could press a button to call staff. One person said, "I use the call bell if want help, they have never let me down; they always come quickly."

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and recorded by staff. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely.

Appropriate checks had been carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People's medicines were managed and given safely. Only those staff who were trained could administer medicines. People's medicine records gave a good level of detail so that staff could support people safely. The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. Medicine administration records (MAR) charts were completed satisfactorily, we saw no gaps in the records, and people's allergies were clearly identified. Information in the care plan and risk assessments matched this information so staff supporting these people had clear guidance in place. Any medicines to be given 'as required' were monitored in line with the provider's policy and protocols. People told us they had confidence in staff, and were able to ask for painkillers when they wanted them.

Medicines were stored and disposed of in a safe manner. All medicines were labelled with directions for use and contained both the expiry date and the date of opening. Medicines were delivered and disposed of safely and appropriately by an external provider.

Requires improvement

# Is the service effective?

## Our findings

The provider had not complied with the requirements of the Mental Capacity Act 2005 (MCA). Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were not always effectively followed. Assessments of people's capacity had not been completed correctly as they were not based on a particular decision that the person had to make. Instead a statement was made of the person's medical condition. Where the assessment recorded that people did have capacity to make decisions, relatives still made decisions about people's care and support, but they did not have legal Power of Attorney for care for the individuals. There was no record that the people had agreed to this.

Because the requirements of the MCA were not effectively fulfilled, this was a **breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care services are looked after in a way that does not inappropriately restrict their freedom. Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. The registered manager also ensured that people's care was given in line with the approved DoLS to ensure that people's human rights were protected.

People's consent was sought before staff gave care or support. Staff had received training in what the MCA was about, and how they needed to put it into practice. Nurses were heard to ask people if they wanted their medicine, or if they would like an item of protective clothing removed. They also asked how people were feeling and if they were in any pain.

The home was clean and light and airy, however few adaptations had been made to meet the needs of people that lived with the experience of dementia. For example signs identifying doors were the same colour as the door so did not stand out; doors and door frames were all the same colour so would not be easy to notice; Some carpets around the home had busy patterns that could cause confusion to people. One corridor of the home had an unpleasant odour due to the continence needs of a person. During our inspection we did not see anyone become confused by the décor, however **It is recommended that the provider investigate best practice around adaptations that can be made to care homes to better meet the needs of people, especially those who live with the experience of dementia.**

People's dietary needs were met and they received support with any specialist diets. People were supported to have the food they liked. One person told us about their favourite food, "The food is good, and I get the things I like to eat. I am always given a choice of food." The registered manager had ensured that this was always available in their room, with clear instructions to staff.

Care staff, including the chef, were able to tell us about individual people and their dietary requirements, for example those that were on soft diets as they had a risk of choking, enriched diets if they were losing weight or their dietary choice due to their spiritual belief. Guidance was given to staff on the actions to take if people's weight changed. Records recorded appropriate action had been taken by staff in accordance with these guidelines.

People were involved in the menu planning. One person said, "They ask us about the menus to see what we want." Another said, "They bring the menu in to me, we discuss and I suggest things – it's negotiable."

Religious or cultural food choices were respected and supported by staff. Specialist meals had been prepared for these people to enable them to continue to follow these beliefs.

Staff had appropriate training to undertake their roles and responsibilities to effectively care and support people. People and relatives told us that care staff had sufficient knowledge and skills to enable them to care for people. One person said, "I think staff are well trained and can provide me with my support needs."

Staff told us that they felt supported in their work. They had opportunities to meet with their manager to discuss their performance. Records showed that regular one to one meetings had taken place so that staff could discuss any

Requires improvement

# Is the service effective?

concerns, or training needs they may have. All new staff undertook induction training. Induction training included moving and handling, fire safety, safeguarding, and shadowing experienced colleagues. Staff also attended training in topics related to people's specific needs, such as dementia and diabetes. Refresher training was regularly arranged to keep staff's skills and knowledge up to date.

People were supported to keep healthy. They had regular access to health care professionals such as GP, opticians and dieticians. People also had a choice of three GP practices to use. As most people were local this meant they were able to keep their own GP.

Requires improvement

# Is the service caring?

## Our findings

We had mostly positive feedback from people we spoke with about the caring nature of the staff. One person said, "Staff are extremely good since I have been here from the first day, without their care I would be lost; They'd do anything for me." Another person told us that staff were, "Really kind." However another person told us, "I'm a bit lonely up on the top floor."

People were not always treated in a caring or respectful manner. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner; however their actions were not always as caring as they could be. For example a person was given eye drops in the lounge area. This was not very dignified and the staff member did not respond to a request made by the person. They had asked if they could have something to hold under their eye to stop the drops going down their face. The staff member stood up, looked around and said there wasn't anything. They then attempted to give the eye drops, but the person had difficulty tilting their head fully back, and became upset. Good interaction was seen displayed by the activities person as they went over and talked with the person and cheered them up.

Two people had drinks bought in for them by a member of staff. However another person in the room had an empty cup, they held the cup up and looked at it as the staff member walked past with the other two drinks. This indicated their cup was empty. This movement was not seen by the staff, so the opportunity to ask the person what they wanted was missed. This was an example of staff being very task focused.

During lunch a person was left in the back of the dining room at a table in front of a blank wall, by staff. This went on for at least 15 minutes. We could not see any reason why this person could not sit in the main dining area with the others. This person was not very responsive, so just sat where staff left them. They did not indicate they were in distress or wanted to move. Staff were seen to walk past them without acknowledging the person was there.

Another example of the inconsistent way that staff showed care and respect was seen where staff supported people to eat in their rooms. Two of the four staff had little interaction with the people they supported. The only conversation was asking if they wanted any more. One staff member had positioned themselves between the television (which was on) and the person in bed, blocking their view. Good examples were seen with the other two staff were heard to talk with people, asking how they liked the food, and they had general chit chat with them, which made the meal more enjoyable and a caring experience for the two people.

At one point a member of staff was engaging in conversation with a person, when the registered manager came into the room and said they had a telephone call for them. The staff member left the person to take the call. The call was not urgent and when it was over they did not return to complete the conversation they were having with the person. A staff member was also overheard to say, "Good boy" to a person which could be seen as condescending.

Due to the above inconsistencies in how care was given, **it is recommended the provider reviews best practice guidance in providing dignified and respectful care and support.**

Some caring interactions were seen during the day. When staff took somebody into the conservatory area they put their arm around them to guide them sensitively; the member of staff was smiling at people as they worked. Another member of staff did nail care with a person who enjoyed the experience.

Information had been given to people about their care and support, in a manner they could understand. Staff were seen to explain to one person why it was important for her to keep drinking, as the day was very hot today and they didn't want them to get dehydrated. Staff spoke with people at a pace and in a manner which was appropriate to their levels of understanding. Another example was by the format of the menu which used pictures so it was easier for people to understand what each dish was. The information on display was the correct menu for today. Large print text was also in use for people who found it hard to read small text.

People's privacy, dignity and confidentiality was respected by staff. When asking questions of a personal nature staff spoke quietly and close to the ear of the person to reduce the risk of others overhearing their conversation. Care records and other personal documents were kept securely so they could not be accessed by unauthorised people. People looked well cared for, with clean clothes, tidy hair and working hearing aids where they were used.

Requires improvement

# Is the service caring?

People had access to advocacy services if they wished. These are people who will come and help the person make a decision, if they have no one else to help them, such as a family member. Where people may need someone to help them make a decision.

People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. The registered manager told us they had residents and relatives meetings, notice boards, and events celebrations to involve people in the home.

Appropriate information was given to people regarding their care. Care plans showed the person who used the service and their relative had contributed to the development of their care and supports needs. There was a contract between the home and the person living in the home. The manager together with people and/or their relatives held care review meetings which also gave people the opportunity to be involved in their care

Staff knew the people they cared for. Positive relationships that developed between residents and staff by ensuring that staff find out about them. Key workers are allocated so that people have an individual associated with them.

Requires improvement

# Is the service responsive?

## Our findings

Some people had access to a range of activities; however these needed to be more focused on individual's interests and needs. While some people did have individual access to things that interested them, such as crafts and model making, others were left for long periods with little to keep them interested, especially those that stayed in bed all day. One person in the lounge was observed to be in the same seat for over two hours. The only engagement they had with others was when a nurse asked if they would like their medicine, and later when they were asked if they wanted a drink. Their chair was positioned so they could not see the television, so they had no visual stimulus. They spent most of this time drifting in and out of sleep.

Activities that were available to people on a group basis included a weekly visit from a 'pat the dog' service, film club, skittles and exercise. However on the day of our visit the activities displayed on the planner did not take place. When the activities person asked three people if they would like to do some exercises they all said no. The plan was that they would exercise in the main lounge area, where everyone could see them. The day was very pleasant with warm sunshine, but no one was asked if they would like to try the exercises outside, or in a more private and appropriate setting.

People were able to practice their religious or cultural beliefs; However the services all came to the home, with no one having the opportunity to go out and practice their faith in the community. The home visits were not carried out each week, so someone that may wish to celebrate their faith each week did not have the opportunity.

**It is recommended that the provider review the provision of activities to ensure they meet the needs of individual peoples hobbies, interests and needs, especially those living with dementia.**

People gave a positive response when asked about their involvement in their care and support planning. One person said, "Yes, I have a care plan, staff go over it with me every now and then." Her preference to be involved in her care plan was recorded in her care file, so staff were acting on her wishes. Relatives confirmed that the family had been always been involved in completing the care plans where people could not be involved themselves.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. Relatives confirmed the staff had visited their family member to carry out an assessment of the needs. Two relatives described how the staff had, "Spoken with the person and the family to find out needs and preferences." The staff had also explained that the care plan would be further developed when the person had moved in and they got to know him better. Both relatives were, "Very happy with the communication from the home."

There was good communication in the management of people's care between the provider and external professionals such as GPs and community nurses. Advice and guidance given by these professionals, for example in the management of wound dressings, had been followed by staff and properly documented. For example where a person had been visited by a Speech and Language Therapist (SaLT) their care documentation had been updated to take into account the new care support recommendations. The care plan had been updated, and the Chef had a note on his white board in the kitchen, and was aware of the change. Food given to the person matched the new guidance to enable them to swallow easier.

People were supported by staff that listened to and responded to complaints. People and relatives knew how to raise a concern or make a complaint. One person said, "I would grumble to the person who manages the complaints." They went onto say they had never felt the need to make a complaint, but felt staff would listen and take action if they did.

There was a complaints procedure in place and people had access to a copy. It was stored in the person's folder in their bedrooms, so was easily accessible to them. It gave details of timescales the staff would respond by. If people were not satisfied with the initial response it also included a system to escalate the complaint to the provider. The policy was also displayed on the notice board so that visitors to the home had access to it.

Good

# Is the service well-led?

## Our findings

People and relatives were included in how the service was managed. The registered manager ensured that various groups of people were consulted for feedback to see if the service was meeting people's needs. The provider sought feedback from people and relatives each year by the use of questionnaires and meetings. The results from the last survey had been compiled and a report was generated. This was then discussed during staff meetings so that staff could see how they had done. People were also able to leave feedback by the use of leaflets that were on display in the reception area. These could be sent directly to the provider and people could fill them in without having to ask staff.

Staff were involved in how the service was run. Along with regular one to one meetings with their line manager, they were also invited to staff meetings. This provided the staff team an opportunity to discuss any issues or updates that might have been received to improve care practice. Minutes of the meetings recorded what actions had been identified and also reviewed previous actions that had been raised to ensure they were completed. Additionally there were staff engagement meetings, which were not attended by the registered manager. This enabled staff to speak up and this feedback was then fed back to the registered manager in confidence.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken. For example, pressure areas developing or increasing numbers of falls could indicate poor care. Information for staff and others on whistle blowing was on display in the home. Staff understood what whistle blowing was and that this needed to be reported.

There were clear processes in place for reporting incidents and accidents. Incidents were reviewed by the registered manager to identify any patterns that needed to be addressed and how these were being followed up. Staff told us that they meet after an accident or incident, to look at the reasons they happened and ways to avoid them in the future.

The provider, registered manager and other senior staff checked to ensure a good quality of care was being provided to people. There were records of audits to assess the safety at the home and whether the home was running as it should be. A senior manager did a monthly report on all aspects of the home. The registered manager did a weekly audit of the building and regular care plan checks. There were audits for the safety of the building, finances, and more regular checks like the water temperatures. There were monthly meals monthly audits and training audits.

People's feedback was sought to help improve the service.

The home had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, independence, respect, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**There were not enough staff deployed to meet the needs of the people that lived here.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>**The provider had not fulfilled the requirements of the MCA. Capacity assessments were not completed correctly, and decisions were made for people by others who may not have the legal rights to do this.** |